University of Alberta

Seeking Wholeness: Experiences of Making Choices in Menopause

by

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A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of Master of Science

in

Family Life Education

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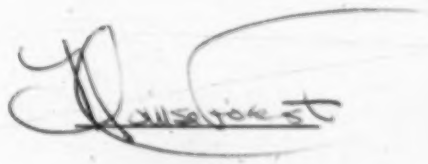

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ABSTRACT

This study offers insight about the decision making process for women who are making complex decisions about a real life issue. Grounded theory methods were used to guide the research and to answer the research question which was to understand how women make choices about how they will manage their menopause experience.

The process of making decisions in menopause was represented through intricately connected themes reflecting the very personal nature of women's decision making. Achieving wholeness in their lives evolved as the core category of the study.

Because making decisions in menopause is intricately interwoven with a woman's personal resources and life circumstances, women will make a variety of decisions about menopause as their circumstances change. Implications from this study are for educators and health care providers to embrace a collaborative role in their interactions with women and to listen more carefully with an emphasis toward education, prevention and wellness.

ACKNOWLEDGMENTS

Listen to those inner signals that help you make
the right choices - no matter what anyone thinks.
In Everyday Wisdom
Wayne W. Dryer

Three years ago I began a new journey. It has been a difficult journey at times and has caused me to constantly question my abilities and my worth, but it has taught me many things. It has taught me to trust my instincts. It has taught me to have faith in my abilities. It has taught me that when I listen to those inner signals, I make choices that are right for me. A risk becomes a wonderful challenge. Thank you to all those who believed in me. And the journey continues...

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CHAPTER I

Statement of the Problem

The real voyage of discovery consists
not of seeking new landscapes but in having new eyes.
Marcel Proust

Like my 40-something circle of women friends, I am nearing menopause. Unlike most of my friends, however, I find myself in the unique position of being able to experience this life event not only as a participant, but also as an observer and a researcher.

In Canada today over 3 million women between the ages of 40 and 60 are going through menopause (Statistics Canada, 1990). The term menopause refers to a woman's final menses; a woman who has not menstruated for 12 consecutive months is considered to be postmenopausal. In common usage, as within this study, the term menopause or menopausal is more inclusive and is used to designate the period of time preceding and following the last menstrual cycle (Coney, 1991; Cook, 1993; Health Canada, 1995a; Kaufert, 1986; Kaufert & Gilbert, 1986).

Menopause is a complex process of change and transition that each woman will encounter as her body adjusts to lower levels of hormone production. Just as her menstrual cycle is unique to her, so will be her experience of menopause. While the physical and emotional changes may be numerous, the intensity of these changes will be influenced by the unique way her body responds to the alterations in hormonal levels (DeMarco, 1996).

Menopause encompasses many dimensions that extend far beyond the physiological consequences of hormonal changes in a woman's body. It acts as a marker of aging. It is a time of personal re-evaluation of self in relation to family, sexuality, workplace and life goals (Health Canada, 1995b; Quinn, 1991). Many of the feelings and emotions a women experiences during this time are a function of her contentment with who and what she is at this juncture in her life. Other feelings and emotions are more globally based, predicated upon the social realities confronting women in a Western culture in the 1990's (Health Canada, 1995b). The ability to incorporate the many changes associated with this transition into the context of a woman's personal identity is influenced by many factors including her general health, her cultural background, the socioeconomic environment, her employment history and her level of education. The presence of a support system provided by an intimate partner, family, and community also plays a significant role in how this transition is experienced (Koster, 1991; Woods, Lentz, & Mitchell, 1993).

Over the course of the past few years I have had the opportunity to talk with many women friends and associates who, like me, were in the process of making decisions about how they would manage menopause. These discussions led to a growing desire to more formally inquire about this experience. As a component of my graduate work, I arranged a practicum experience with the purpose of investigating programs and services specifically directed to the health promotion needs of mid-life women encountering menopause in the Edmonton area. This experience provided me with the opportunity to talk with many other women. I began to develop an awareness of the complexity of the issues mid-life women face in their desire to understand and to manage this transition.

The experience has been a process of discovery but one which raised more questions for me than provided answers. I encountered women struggling with bothersome and debilitating menopausal symptoms, and others who found the transition of menopause only mildly inconvenient. It was clear, though, that most women also viewed this period in their lives as one of growth and renewal; a time to revisit personal goals, beliefs and values. I discovered there was a common bond that was shared--a community of women seeking to support each other during this time through talking, teaching and sharing common experiences. No matter how women came to define this transition for themselves inevitably, however, each woman was faced with having to make choices and decisions about how she would manage this experience in a manner which was meaningful for her. The process did not always seem to be easy.

Women seeking to make choices and decisions about how they will manage their menopause find themselves enmeshed in the controversy and debate which has surrounded the management of menopause for decades and still continues to complicate decision making today (Bowles, 1990; Coney, 1991; Kaufert, 1986; Leiblum & Swartzman, 1986). Is menopause a medical condition that requires treatment or a natural event? As Logothetis (1991) suggests, the divergent opinions and recommendations to which women are exposed may in fact compromise their ability to make an informed decision. Because physiological changes in a woman's body are related to the decrease in estrogen it is easy to understand why women in mid-life begin to explore hormone supplementation. Major questions, however, revolve around the issues of hormone therapy and its relationship to osteoporosis, cardiovascular disease and cancer (Bond, 1991; Henig, 1994; Garner, 1991; Maddox, 1992; Stampfer, Colditz, & Willett, 1990).

These concerns, as well as a woman's beliefs about menopause and the values she holds about herself as a woman, lead many women to explore other options.

These issues reflect the dilemma that many of my women friends and other women I talked with have expressed. They spoke of the varied and often conflicting information they found available and of the frustration they felt as a result of their inability to find an alternative, either hormonal or non-hormonal, to alleviate their menopausal symptoms. Some women voiced concern that there did not seem to be one definitive answer for them or for other women. Many women expressed that they did not want to take hormone therapy and resented what they perceived to be the bias of the medical profession to prescribe it over other alternatives. Other women did not share this concern to the same degree and were content with this form of management for their menopause. What was clear was that these issues were not easy ones for these women.

Since women can be expected to live approximately one-third of their lives after menopause (Cook, 1992), the self-care practices they embrace to achieve and maintain their own health are significant. Yet few studies about women as active and responsible decision makers in relation to mid-life issues exist (Bernhard & Sheppard, 1992; Woods, Lentz, & Mitchell, 1993). It is important to address this lack of information about the choicemaking processes of mid-life women since many of the decisions to be faced are not without risk and just as importantly it is long overdue that women are given the opportunity to become partners in decision making regarding their health and well-being.

While it is recognized that health care providers bring knowledge related to diagnosis and treatment options to the decision making process, it must also be recognized that women bring their own expectations for achieving health and well-being,

including a set of values and a lifetime of experiences. If we are going to advance health knowledge and health promotion practices that are relevant and useful to mid-life women, if we are going to accept them as partners in making choices and decisions, we need to better understand mid-life women's views of the issues, their personal motivation and goals. It is also critical to understand the process by which women make choices that are relevant and meaningful for them about their menopause.

It is my belief that as educators and health care providers, we need to hear from women themselves. We need to understand women's experiences and their perceptions of this transition. By understanding how women view menopause, the decisions they make in order to manage their menopause and why they make the decisions they do, it will be possible to offer educational programs and health care that reflects the information and support women need. It is important to me that the voices of women are heard and respected in this process.

Statement of the Problem

The purpose of this study is to understand, from the perspective of women, the process of making deliberate choices to manage the issues associated with the transition of menopause during mid-life. The research question which will guide this study is as follows: What is the process that women embrace when making choices about how they will manage their menopausal experience?

CHAPTER II

Review of the Literature

Menopause is a complex issue and one that women themselves are only beginning to explore more openly. It can be concluded from the literature that women clearly indicate a strong desire to participate in the decision making process surrounding this life transition (Logothetis, 1991; Rothert et al., 1994; Salazar, & Carter, 1993; Ward, Heidrich, & Wolberg, 1989). However, we know very little about the decision making process that women embrace when they make deliberate choices to manage the issues associated with menopause.

A literature review was conducted to examine existing research which would more clearly define the parameters of women's management and choicemaking relative to the issues created by the menopausal transition at mid-life. As a beginning, I felt it was important to look to the literature in order to give clarity to the historical and cultural context that influences the meaning women give to menopause and ultimately their choices and decisions. Such a focus provides a perspective from which to examine the context for women's decision making today. Although there are many factors which women must consider when making choices and decisions about menopause, this review will focus on the primary issues centering around the use of hormone therapy and natural therapies as choices in menopausal management. The final section of this review will look to the nature of women's decision making. Because the literature is not rich in detailing the choicemaking process for women making decisions about menopausal management, women's choicemaking in relation to other health issues as well as those

studies which do address aspects of women's decision making in menopause will be discussed.

This review will therefore be divided into the following sections: the context for the decision making which will consider the cultural and historical context of menopause and women's decision making, as well as the context of decision making for women today; the nature of the choices for women which are influenced by the issues surrounding the use of hormone therapy or natural therapies in menopausal management; and, the nature of women's choicemaking process in relation to menopause and other specific health issues often faced by women.

The Cultural Context of Menopause and Women's Decision Making

I believe we are products of our place in time, our culture, our history. If this is so, then the influence of our past beliefs and values about women in mid-life and the transition of menopause should be considered in order to provide a perspective from which to understand the beliefs and values that are held today.

It has been stated that "language expresses the culture of its speakers, it guards their traditions and directs their future" (Wilbush, 1981, p. 1). This has been especially true regarding menopause. The language which has been used to describe and explain menopause has been inundated with illness oriented phrases referring to menopause as deterioration, deficiency disease, and estrogen starvation (Bell, 1990; Kaufert & Gilbert, 1986). The personal, social and cultural prejudices of the time are reflected in such words and project a distinctly negative image of aging women and of menopause. How has our Western culture come to hold such views?

Climacteric disturbances were rarely recorded prior the end of the 19th century. It was at this time that changing social conditions, including the rise of the middle class, changes in family structure and in the status of women, began to influence women to turn away from their traditional healers such as midwives, and instead turn toward physicians. For the first time, large numbers of medical men began to focus on menopause and the climacteric (Formanek, 1990; Wilbush, 1988).

The dominant view held by physicians of this era was that menopause was a physiological and psychological crisis that caused disease including tumors, tuberculosis, diabetes, depression, hysteria and insanity (Formanek, 1990; MacPherson, 1990). Increasingly menopausal women's vulnerability to nervous and mental, as well as physical illness was stressed (Formanek, 1990). The explanation for why menopause was so problematic ranged from the notion of a woman having too much education, past attempts at birth control or abortion, undue sexual indulgence, insufficient devotion to husband or children, or even the advocacy of women's suffrage (MacPherson, 1990).

With the discovery in the early 1920's that women's ovaries produced the two hormones estrogen and progesterone, menopause began to be considered as a disease related to a deficiency of these sex hormones (MacPherson, 1994; van Keep, 1990). The discovery of these hormones paved the way for the possibility of treating this "hormonal deficiency" in women with hormone therapy (Bell, 1990). Although physicians did not consistently agree on what constituted menopausal signs and symptoms, they did agree on two basic assumptions: menopausal women should be managed by physicians, and medical intervention was a given (MacPherson, 1994). It could be suggested that medical science narrowed the vision and the understanding of menopause to the exclusion of

social, psychological and environmental factors which defined individual women's experiences.

Our most influential information about menopause has come from the medical community. Almost exclusively, it has been the documentation of women seeking medical help for their menopausal symptoms which has formed the basis of the formal literature describing women's menopausal experience (Bell, 1990; Coney, 1991). The description and management of symptoms associated with menopause became the benchmark for understanding this transition. Such a perspective has contributed to the belief that menopause is problematic, or a disease process, and that women require medical care and attention for it. It follows that such a perspective has helped to foster myths and stereotypes of menopause and of women's experience in mid-life.

Another factor which has influenced the beliefs and values we hold about aging women has arisen from our culture's understanding of human development, particularly in mid-life. The middle years have been a largely unexplored phase of human development and this has been particularly so in relation to the experience of women (Bowles, 1990; Gergen, 1990).

Our understanding of women's adult development has been greatly influenced by the writings of Sigmund Freud (Freud, 1965; Gergen, 1990), who emphasized the passivity of a woman's nature and defined her adult development by her capacity to reproduce children and to mother them. It was Freud's premise that women who rejected their traditional female role and chose to compete as men, did so because of their own unsatisfactory and immature development. It was Freud's view that a normal, mature woman was a dull and stunted creature.

It seems that women's roles in society and as a consequence, their value, have been interrelated with societal changes which have dictated the roles that women would assume (MacPherson, 1994). It has been men's accomplishments in the spheres of cultural life, career involvement and public service which are central to theories of their adult development (Gergen, 1990). In contrast to this view, women's adult identity has most often been described in relation to their ability to bear and to raise children. Marriage and children have been seen as an essential part of a woman's well-being in earlier years and menopause and the "empty nest" are identified as major events of the middle years (Barnett & Baruch, 1978; Carter & McGoldrick, 1989; Erikson, 1968; Lachman & James, 1997).

Of significance as well to the understanding of the issues confronting women who must make choices about how they will manage their menopause is the view that is held of women as decision makers. Historically women have not been viewed as active choicemakers in issues regarding their health. Once again, accounts of women in the 19th century illustrate the relationship between illness behavior and femininity. The more pale, delicate and sickly an upper class woman appeared, the more feminine she was perceived to be (Collier, 1982; Willbush, 1986). Long periods of bed rest were frequently prescribed for normal events such as childbirth. Women were socialized to be dependent, not to seek knowledge, and to let others make decisions and be in control. As a consequence, women have often acted as decision makers in ways that were rewarded culturally, or may not have taken action at all because they had minimal confidence in their ability to effect change (Collier, 1982).

Although our modern expectations of appropriate health behaviors for women are less defined and restrictive than in the previous century, it is likely that historical perceptions and beliefs continue to influence health care practices in subtle ways. The care of women in childbirth is an example where the right to define, control and manage this experience remains largely the prerogative of the medical profession. Other examples include control of fertility which has remained within the jurisdiction of the medical profession as well as other aspects of women's gynecological care (Kaufert, 1982; Miles, 1991; Zola, 1983). The result of such behavior has been that women have often lacked basic knowledge about their bodies and about options related to treatment of common female conditions (Collier, 1982; Dery, 1982; Formanek, 1990; Wilbush, 1988).

Summary

That so little about women's true life experience has been learned and within such a narrow perspective is of consequence to women who must build an image of themselves as adult women in large part from this knowledge base. The meaning that women give to mid-life and to menopause is formulated within the context of this knowledge base. If women see themselves as being of value primarily for their ability to be a wife and mother, then menopause brings a loss of these functions or the possibility of fulfilling these roles. If women define their worth based on youthfulness and beauty, so strongly emphasized in our Western culture, then it is easy to understand why menopause would be seen as a time of decline and loss of status (Frey, 1981). If menopause is associated with physical and mental decline, then it is likely that the achievements and contributions of women in the menopausal age group may even be devalued or dismissed within a profession or workplace, particularly if the workplace is the home (Health Canada,

1995b). If viewed as a disease, women will seek cure from those who hold the power, authority and information about the cures. All decrease personal thinking and action. Viewed from this perspective, it is possible to understand why menopause would not be embraced as a positive life transition to be managed personally, but instead as an event to be anticipated with apprehension and left to others to manage.

The Context of Decision Making for Women Today

While the view of menopause as a physiological event has remained essentially unchanged over the last half-century, expectations about, treatment of, and attitudes toward this transition have changed considerably. Although it is known that women display a considerable range of attitudes toward menopause, it has been consistently documented that most women do not view menopause from an illness orientation (Bernhard & Sheppard, 1992; Frey, 1981; Leiblum & Swartzman, 1986; Quinn, 1991). At the very least, women's attitudes toward menopause tend to be neutral, consistent with the view that menopause is a normal developmental stage in their lives and one that is not better or worse than any other (Barlow, Grosset, Hart, & Hart, 1989; Bernhard & Sheppard, 1992; Frey, 1981; Logothetis, 1991; McKinlay, McKinlay, & Brambilla, 1987; Quinn, 1991; Wilbur, Miller, & Montgomery, 1995).

Few investigators have studied how women's changing life conditions, including their roles, norms, social demands and supports, and personal resources affect their health related behaviors, yet women's life conditions have changed considerably (Woods et al., 1988; Woods, Lentz, & Mitchell, 1993). Women today are better educated, live alone longer and participate in the labor force throughout their life, regardless of their marital status and the age of their children (Statistics Canada, 1990). Women assume a variety of

roles which may include combinations of marriage, career, childbearing, motherhood, and caregiving for aging parents or other relatives. Women today are not only involved in all areas of public life but are also likely to attach great significance to their roles as sources of self-identification and satisfaction (Health Canada, 1995b; Gergen, 1990).

Studies show that women are beginning to reject the image of menopause as a time of emotional imbalance, depression, and the beginning of the end and instead are creating an image of individual growth and aging with vitality (Quinn, 1991). As Quinn suggests, women are demonstrating a confidence and trust in their beliefs which contradicts what they believe is society's pessimistic view about the process. It can be said that women are developing their own symbolic meaning for menopause through their interactions with others and their own self-appraisal (Cook, 1992; Quinn, 1991).

The Issues of Decision Making in Menopause

Decision making in menopause is complicated by the on-going debate referred to earlier. Is menopause a natural event in a woman's life or a condition requiring medical intervention? The definition of the situation is pertinent. If menopause is viewed as a deficiency disease, medical interventions are assumed; if menopause is viewed as a natural event in a woman's life, then medical intervention is not as likely and other alternatives may be considered to be more appropriate. Complicating the issues surrounding this debate, however, is the fact that the signs and symptoms associated with menopause are often ambiguous in meaning. For example, some physical changes may be related to approaching menopause, but they may also be indicative of any one of an assortment of pathologies affecting the reproductive system, including cancer. Diagnosis of these conditions is not open to self-examination, but is dependent on contact with

some form of medical care. Thus, to reject medical intervention is to ignore that the physician's ability to distinguish between the pathological and the nonpathological may be critical for some women (Kaufert, 1986; Leiblum & Swartzman, 1986).

The definition of menopause as a disease condition or a natural physiological event influences the nature of the decisions a woman will make about the management of her menopause, as well as who will assume primary responsibility for making these decisions. Historically, the management of menopause with hormonal therapy is consistent with the view that menopause is a deficiency disease, while other alternatives such as the use of vitamins and herbs, changes to diet and exercise regimens, acupuncture, naturopothy and homeotherapy are associated with more natural approaches.

The wide variety of alternatives and the on-going debate about the appropriateness of the alternatives have led many women to feel confused about their options, particularly about the risks and benefits associated with those alternatives that are available (Lack & Holloway, 1992; Leiblum & Swartzman, 1986; Logothetis, 1991; Swartzman & Leiblum, 1987). Clearly each individual needs to evaluate her own personal situation carefully. Accurate knowledge about normal changes due to decreased estrogen production, the pros and cons of a therapy, as well as an appraisal of her personal health and her own beliefs, are all examples of factors which a woman must consider in deciding whether hormone therapy or some other option is most appropriate for her (Maddox, 1992). It is not an easy decision and because no uniform recommendation is applicable to all women, each woman must make a personal choice.

The Benefits and Risks of Hormone Therapy as a Choice in Menopausal Management

The use of estrogen to alleviate menopausal symptoms was first proposed in 1932 (van Keep, 1990). The 1940's and 1950's saw an increase in experimental and therapeutic use of hormone therapy, including the treatment of climacteric disturbances (Wilbush, 1988). During the 1960's the use of estrogen therapy was popularized by the writings of Robert Wilson who viewed the postmenopause as a period of estrogen deficiency and theorized that if all women would accept estrogen therapy, they would have a trouble-free menopause (Wilson & Wilson, 1963, p. 4). The following passage reflects his thinking.

> ...You might think of menopause as a deficiency disease...similar to diabetes. Both are caused by a lack of a certain substance in the body chemistry. To cure diabetes, we supply the lacking [insulin]. A similar logic can be applied to menopause--the missing hormones can be replaced.

The use of estrogen therapy to alleviate menopausal symptoms increased by 187% (Swartzman & Leiblum, 1987) in the 10 years following the publication of Dr. Wilson's book, Feminine Forever (Wilson, 1966), and remained a prevalent option until the mid-1970's. At this time, concern was raised when two studies reported an association between the use of estrogen therapy and endometrial cancer (Smith, Prentice, & Thompson, 1975; Ziel & Finkle, 1975). This finding resulted in a significant decrease in the popularity of prescribing estrogen for the management of menopausal symptoms. This change in attitude was clearly demonstrated by the subsequent decrease in sales of estrogen supplements by 34% during the short time span between 1975 and 1979 (Swartzman & Lieblum, 1987).

In recent years, the use of hormone therapy has been strengthened by the discovery that adding progestin to estrogen therapy appears to prevent the increased endometrial cancer risk due to unopposed estrogen (Andrews, 1995; Roberts, 1991; Weinstein, Bewtra & Gallagher, 1990). It has been suggested that added progestins may have the same protective effect for breast cancer; however, there are few data concerning the effect of estrogen plus a progestin on breast cancer risk that are conclusive (Gambrell, Maier & Sanders, 1983; Grady & Ernster, 1991; King, 1996; King & Kerr, 1996).

The disease oriented view of menopause has remained prevalent, strengthened by epidemiological studies published since 1980 indicating the protective effect of estrogens against the occurrence of cardiovascular disease (Barrett-Connor & Bush, 1991; Nabulsi et al., 1993; Stampfer & Colditz, 1991; Stampfer et al., 1991) and in reducing a woman's risk of suffering from osteoporosis (Andrews, 1995; Christiansen & Riis, 1990). As a result, medical attention has shifted from the short-term resolution of immediate menopausal symptoms such as hot flashes, to the prevention of long-term effects on the cardiovascular system and bones of older women (Wilbur, Miller & Montgomery, 1995). The evidence of the impact of estrogen on these systems is increasing, but is still incomplete. The next sections will summarize current knowledge pertaining to these health issues.

The Issue of Hormone Therapy and Osteoporosis

All women to some degree eventually develop osteoporotic changes, but one in every four women older than 45 years has progressive loss of bone mass that results in fractures (Bond, 1991; Nilas & Christiansen, 1987; Nordin, Need, Chatterton, Horowitz, & Morris, 1990). Estrogen remains the most effective known treatment for decreasing

bone loss postmenopausally (Ravinkar, 1992); cumulative data suggest that estrogen therapy can also play a significant role in reducing the incidence of fractures in aging women (Laura, 1987; Ravnikar, 1993).

Most bone loss occurs in the first three to six years after menopause. Smaller amounts of bone loss occur for up to 20 years after menopause. However, there is no agreement among physicians as to how long hormone therapy should be continued to prevent bone loss. Because it is unclear which women would actually benefit from long-term estrogen therapy for protection against osteoporosis, it is suggested by some that all women should take estrogen beginning at menopause and many doctors now recommend taking hormone therapy indefinitely (Andrews, 1995; Christiansen & Riis, 1990; Ravinkar, 1992). The dilemma for women considering hormone therapy as an option is that it is unclear how long it must be continued to maintain the benefit. Of particular significance in weighing the risks and benefits of hormone therapy as a choice in menopausal management is the fact that discontinuation leads to a phase of accelerated bone loss, like that which follows natural menopause, and protection against fractures may therefore be lost five or more years after estrogen therapy is discontinued (DeMarco, 1996; Ravinkar, 1992).

The Issue of Hormone Therapy and Coronary Heart Disease

The biggest increase in coronary mortality among women occurs around age 50, approximately the time of menopause (Stampfer, Colditz, & Willett, 1990). Current findings indicate that although natural menopause does not cause an immediate increase in risk of heart disease, it does signal a period of increasing risk that is thought to be related both to age and to estrogen deficiency (Stampfer, Colditz, & Willett, 1990). The

preponderance of evidence from epidemiologic studies strongly supports the view that postmenopausal estrogen therapy can substantially reduce the risk of coronary heart disease (Barrett-Connor & Bush, 1991; Nabulsi et al., 1993; Stampfer & Colditz, 1991; Stampfer et al., 1991). With evidence from over 30 epidemioligic studies indicating that postmenopausal women who take estrogen are at a lower risk for coronary disease (Grodstein & Stampfer, 1995), the link between estrogen therapy and the prevention of cardiovascular disease is now well established.

Despite the tremendous evolution of knowledge regarding the use of hormone therapy for the treatment and prevention of coronary heart disease, women considering hormone therapy as a choice do so in an environment characterized by many still unanswered questions. Although practicioners are currently recommending hormone therapy for many women, they do so in the absence of more complete information which is needed from longitudinal, randomized and controlled studies with large numbers of women (King, 1996; King & Kerr, 1996). According to Grondstein (1996), although consistent findings suggest a link between the use of hormone therapy and a reduced incidence of heart disease, cause and effect remains unproven. The rationale for this view arises from the knowledge that women who choose to use estrogen may also make other choices that could be associated with reduced rates of heart disease.

It is generally recognized that hormone users are healthier than nonusers (Grodstein, 1996; Matthews, Wing, Meilahn, & Planaga, 1996). Women who take estrogen when compared to women who do not have been shown to be of a higher economic status, better educated, more physically active, have lower blood pressure and generally weigh less (Barrett-Connor, 1991; Matthews, Wing, Meilahn, & Planaga, 1996;

Stampfer et al., 1991). All are characteristics which predict lower risk for coronary heart disease. The question must be asked if the link between hormone therapy and coronary heart disease represents a true protective effect of hormone therapy.

The Issue of Hormone Therapy and Breast Cancer

A significant risk associated with hormone therapy use and the one of which women are the most fearful (Ravnikar, 1993), is a possible increase in the rate of breast cancer among its users. Assessing the impact of estrogen use on the risk of breast cancer is one of the more confusing issues for women. Studies on hormone therapy that are emerging must be interpreted carefully and many questions cannot be answered until more data emerge (Speroff, 1992). There appears to be growing consensus that short-term use of estrogen (under ten years) is not associated with an increased risk of breast cancer (Grady & Ernster, 1991). This suggests that women who take estrogen for a few years for treatment of menopausal symptoms will not have an increased risk of developing breast cancer. However, short-term use of estrogen does not provide the protective benefits for bone and cardiovascular health. For women who take estrogen for an extended duration (over ten years), risk of breast cancer might be slightly increased by 25% - 30% (Grady & Ernster, 1991), and as a result, the issue of long-term use of estrogen therapy is still open to debate (Bush, 1992; Gorsky, Koplan, Peterson & Thacker, 1994; Grady & Ernster, 1991).

Other Possible Benefits of Hormone Therapy

It is plausible that estrogen therapy has other beneficial effects since estrogen receptors are found on virtually every body tissue. The most significant benefit for a woman choosing hormone therapy for managing her menopausal experience is the relief

provided from hot flushes or flashes. Hot flashes have been shown to affect 68% to 92% of menopausal women (Harper, 1990; Health Canada, 1995a) and no other therapy has been found to be as effective in managing this menopausal symptom (Lichtman, 1991). Preliminary evidence suggests that estrogen therapy may also be beneficial in treating urinary incontinence in postmenopausal women, may improve cognition and memory, and may enhance quality of life by enhancing mood and improving sexual functioning (Andrews, 1995; Bush, 1992; Health Canada, 1995a). These factors become important components in the risk-benefit equation.

Summary

Despite the relatively long-term use of estrogen, the risks and benefits of its use have not been determined in a systematic way (Bush, 1992). Such incomplete and conflicting information adds to the confusion that women face in making informed choices. As has been noted, it is generally concluded that risk of coronary heart disease and hip fracture, both of which are more common than breast cancer, decrease substantially in women treated with hormone therapy. Thus, despite the possible increase in breast cancer risk due to long-duration estrogen therapy, the overall effect of its use is likely to be beneficial (American College of Physicians, 1992; Sotelo & Johnson, 1997). However, many women are more fearful of breast cancer than of heart attack or hip fracture and may choose not to take estrogen despite its possible benefits. In women who are at an increased risk for breast cancer the risks of using hormone therapy may outweigh the benefits.

The Issue of Natural Therapies in Menopausal Management

As an alternative to hormone therapy, or in conjunction with hormone therapy, many women have incorporated other choices and practices into their lives including changing diets, formulating exercise programs, taking vitamins and calcium (Quinn, 1991). The significance of herbal products as another option in menopausal management cannot be overlooked since a high percentage of women report using some form of alternative therapy on a regular basis (Eisenberg et al., 1993; Kozyrskyj, 1997).

It is widely accepted that lifestyle factors influence health. There are those who believe that the prevalence of coronary heart disease, osteoporosis and breast cancer, disease conditions of particular concern to women in mid-life, may be related to inadequate and inappropriate nutrients and to other lifestyle habits and practices such as high caffeine and alcohol intake, smoking and physical inactivity (Bond, 1991; Notelovitz, 1988). Studies have demonstrated healthful effects of diet and exercise in the prevention or management of coronary heart disease and osteoporosis, and have linked such practices to the reduced incidence of breast cancer (Marcus et al., 1992; Kushi et al., 1997; Powell, Thompson, Caspersen & Ford, 1987).

There is also fairly strong evidence that acute and vigorous exercise is known to induce a state of well-being and a reduction in symptoms such as depression and anxiety (Notelovitz, 1988). Vigorous physical activity reduces muscle tension and is also associated with a significant decrease in the state of anxiety. Another common problem associated with menopause is insomnia--this too may be positively influenced by exercise.

As with other options for mid-life women these alternatives for menopausal management are also characterized by conflicting information which complicate the decision making process. There are hundreds of herbs that are recognized in both folklore and scientific medicine. Unfortunately, there haven't been enough large-scale, double-blind trials to prove conclusively that herbal therapy is effective (Cerrato, 1997). Although there have been no significant side effects reported with the use of herbal remedies to help manage menopausal symptoms, their use as an option in menopausal management has not been studied systematically and as a result there has been very little information about the risks and benefits of herbal remedies reported in the scientific literature (Ravnikar, 1993).

Women who choose to manage their menopausal symptoms using herbal products must be aware that in Canada herbal products are not registered as drugs but as foods, and as a result are not regulated in the same way as prescription drugs. Products are not assessed for purity, quality and/or strength, making it much harder to ensure that products contain the dosage that is indicated on the label (Cerrato, 1997; Kozyrskyj, 1997; Sheikh, 1995). Because the concentration of the active ingredient in a herbal product may vary from capsule to capsule, users of herbal products may not realize the potency of the products they are using (Consumer Report, 1995).

Even the choice of incorporating regular exercise into a woman's lifestyle as a management option is not without controversy. For example, the effect of exercise on bone mass is site specific which means that an exercise program which includes only walking or jogging will only improve bone density in the lower extremities. It is suggested that exercise, to be done appropriately in order to positively influence

cardiovascular fitness as well as reduce the risk of osteoporosis, should combine both aerobic exercise at least two times a week for 20 minutes, and weight bearing exercises that improve muscle strength of both upper and lower extremities and the spine, for 30 minutes three times a week (Chow, Harrison, Brown, & Hajek, 1986; Ravinkar, 1993). Such a regimen takes time and commitment and is only a benefit if it is continued for life (Ravinkar, 1993).

In conclusion, I would propose that a review of the literature poses more questions for women who are considering their choices for menopausal management than it offers answers. Why would a woman choose to manage her menopause using hormone therapy? What would prompt her to use other alternatives? The issues are complex. The following section will review some of the literature which offers insight into the nature of women's decision making in relation to making choices about specific health issues and about menopause.

Women and Decision Making

According to Pierce (1993) there is a need for descriptive research to provide direction in two basic decision making situations: where there is no clear consensus among physicians about the best course of treatment and when it is unclear how the individual would value certain alternatives and make trade-offs among them. Some decision making models prescribe what people should do, but do not adequately explain behavior in actual situations. As a result there is a lack of understanding of the decision experience of individuals who are actually faced with real-world choices that affect their health and the quality of their lives (Pierce, 1993).

Although there is limited information regarding the process of decision making for women considering their options in menopause, there are some studies that have been helpful in providing insight about the process women have embraced in choosing options to manage other health issues.

Making Choices About Health Issues

A 1985 study explored what was important to women when they considered their choice for childbirth care after a previous delivery by cesarean section--either a trial of labor or a repeat cesarean section (McClain, 1985). It was noted that their plan of choice was based on medical information and advice, but central to the decision making for these women were social expectations and goals which they perceived as being meaningful for them. These women considered a variety of factors in their decision making such as their ability to bond with their newborn infant following delivery, their plans for future childbearing, plans for employment, the perceived effect of the childbirth choice on their ability to resume their usual routine and social roles as soon and as smoothly as possible.

Reasons for supporting a plan of action were multiple and reinforcing, not single dimensional and unconnected. For example, women constructed strategies in which several mutually reinforcing reasons, both social and medical in nature, led them inevitably toward the same alternative. By "stockpiling" the anticipated benefits of one alternative, women reinforced its attractiveness while the appeal of the other alternative was diminished by cataloguing its disadvantages (McClain, 1985. p. 214). Another strategy these women utilized was to construct vivid scripts of their own past experience

with cesarean section--either positive or negative, which reinforced their decision. Such reinforcement made their decisions consequential and choices developed into strategies.

A later study by Murphy and Harvey (1989) also demonstrated the complex nature of the decision making process related to the same issue--women's choice of a childbirth method following a cesarian section. Once again it was demonstrated that social expectations and goals significantly influenced the decision for a childbirth method. Women who chose to pursue a trial of labor perceived childbirth as a life event with emotional and physical benefits that outweighed the physical risks of an unsuccessful labor. Birth was perceived as a personal, feminine accomplishment and these women wanted to participate fully in the birthing process. They voiced feelings of regret about the loss of control of the birthing process in their previous delivery and disappointment at not being able to interact with their baby immediately following the birth.

On the other hand women who chose to undergo a repeat cesarean section also demonstrated a thoughtful and rational process in coming to their decision. These women believed that the choice of a vaginal birth would be safer for the mother, while a repeat cesarean would provide greater safety for their infant. Their choice demonstrated a willingness to incur the health risks of a cesarean for themselves in order to ensure a safe outcome for the baby. These women also reported that the long painful labor that had preceded their previous cesarian affected their choice of a subsequent birth method. As a result a primary reason for their choice was to avoid an unsuccessful labor.

Murphy & Harvey (1989) concluded that women's decision making was a complex process which involved both internal and external factors. Reasons for the choice of childbirth method, beliefs, feelings about the previous cesarean experience and the desire

to be in control of the decision were factors which were considered and seemed to reinforce each other in the decision making.

External factors also were found to influence the choice of childbirth method. A spouse or partner as a source of support was found to be significant. Knowledge about the medical intervention which enabled the woman to participate more actively and meaningfully in the medical plan was important, as were availability and variety of information, and motivation on the part of the woman to seek out information.

A more recent study examined the decision making process of women deciding on a breast cancer treatment (Pierce, 1993). Women in this study did not exhibit a single, clear pattern of decision making but instead demonstrated three different decision making processes which reflected personal variations in considering their alternatives for a breast cancer treatment.

Deferrers were older women who declared a preference based on the immediate appeal of one option. These women did not report the need to read nor seek information and did not consider risk in their assessment of the alternatives. They spoke of wanting the easiest, quickest, and least painful alternatives so they could get on with their lives. Deferrers could not describe their decision making processes. They did not know how they made their choice, and many did not believe they had made a choice.

Delayers (44%) appeared to structure the decision problem in a way that allowed consideration of at least two options. Because their deliberation was random and superficial, these women appeared to compare options only until one option clearly dominated the other or until the first difference between them was perceived.

Deliberators (15%) expressed a personal responsibility for making a quality decision. It was important for these women to have a sense they were controlling events in their lives they thought were possible to control. A unique feature of this style was the construction of a mental strategy. Declaration of a choice did not come about until the woman was confident she had considered all the relevant information and found an alternative that satisfied her major requirements. Conflict existed throughout the process, in part because these women sought information about risks and possible untoward results of treatment.

Choicemaking was explored in the *Choices & Changes: Mid-Life Women's Choicemaking About Menopausal Management* research project (Kieren, Edwards, & Brook, 1996). The majority of women in this study described themselves as skillful in handling choices at mid-life and felt they were responsible for making their own decisions in most aspects of their daily lives. When asked specifically how they made decisions about mid-life issues, these women once again described themselves as being active in the decision making process although the majority indicated they made such decisions with some consultation. Belief in self, ability to gather information, supportive friends and personal decision making skills were mentioned as being important factors in making decisions.

Findings from these studies would indicate that making real life choices and decisions is a process which incorporates a complex matrix of decision making skills, personal beliefs and values, and life circumstances. Most significantly I believe these studies demonstrate that women thoughtfully and rationally consider a variety of factors

in making their decisions. They bring their own perspective about what is important to the decision making process and this cannot be disregarded.

Making Choices in Menopause

In many respects, the complexity of the decision making process regarding menopause is reflected in the following, rather "tongue in cheek" passage taken from a recent lay publication, Dr. Susan Love's Hormone Book (1997).

> So what now? You've got the hot flashes and you can't decide whether to stock up on herbs, buy a bike, or take a pill? Or maybe you should take all three? Your doctor told you to go on hormones to prevent osteoporosis, but you're not sure whether or not you want to. You agree that menopause is just a normal phase in your life, but that doesn't mean it's comfortable. How are you going to 'manage' it? It would be nice if you could just say, 'Of course I'll take hormones'or 'Of course I won't.' As you've realized by now, it's not a simple decision (p. 275).

Do women really want to become involved in decision making regarding menopause and can they become informed enough to participate actively in the process? Recent studies have demonstrated that women can process complex information, understand the implications of choices and apply the information with consistency. As well, it has been demonstrated that women clearly indicate a strong desire to participate in the decision-making process (Logothetis, 1991; Rothert et al., 1994; Salazar, & Carter, 1993; Ward, Heidrich, & Wolberg, 1989). In general, though, the literature is not rich in detailing the choicemaking process for women making decisions about menopausal management or about other mid-life issues.

Few studies have specifically investigated women's beliefs about hormone therapy and how they decide whether or not to incorporate this choice as part of their strategy for menopausal management. Moreover, how women's philosophical views of menopause influence their decisions, which may be a significant factor influencing the decision making process, have not been thoroughly investigated.

One study which has explored these issues was conducted by Logothetis (1991). The focus of Logothetis' study was women's beliefs about menopause and their decision making process regarding whether or not to use estrogen therapy. It was found that women's decision making was based, to a large extent, on their perceptions of the therapy's benefits weighed against its possible limitations. A second finding suggested that the degree to which a woman considered menopause as a disease to be medically managed was an additional factor in explaining how likely she was to use estrogen therapy. Women's decisions were not based, to any great degree, on how susceptible they felt to future menopausal problems or on their perceptions of the seriousness of menopausal consequences. Such a position is, of course, in clear contrast to current medical recommendations regarding the consequences of menopause in later life, such as osteoporosis and cardiovascular disease.

Another largely quantitative study considered how women viewed information when making a judgment regarding the use of hormone therapy for the management of hot flushes associated with menopause (Rothert et al., 1990). Two hundred and eighty three women from a university community considered eight possible choicemaking situations using a survey instrument. Nine of the women were interviewed at a later time to discuss their reasons for choosing the option they did. Women in this study

demonstrated patterns in their use of information regarding hormone therapy and different values of importance related to the same information. For these women there appeared to be more than one way of looking at a decision. A significant finding from this study was that the women appeared to attribute more importance to the disruption caused in their daily lives by hot flashes, than morbidity and mortality risks associated with hormone therapy. As a consequence, it was suggested by the researchers associated with this study, that too little value may be being placed on process factors by health care professionals when they discuss options with a client.

Conclusion

While there is a growing awareness that research must pay attention to the first-person experiences of women, it is in the area of mid-life women as active and responsible decision makers regarding health issues that full, contextually rich descriptions are most vital and most lacking (McBride & McBride, 1981). No area is more in need of exploration from a woman's perspective than how women act to make deliberate choices to manage issues associated with menopause.

The literature which has been cited in this review has demonstrated that the choices and decisions which confront women who are considering how to manage their menopause are not easy ones. Complicating the issues are unanswered questions about hormone therapy and the lack of formal, scientific study of the natural alternatives a woman might consider.

The nature of the research which has been conducted is helpful in demonstrating that what induces a woman to act is a complex phenomenon influenced by personal and social variables which strongly affect what she decides to do. Studies about women's

decision making offer insight into the characteristics of the process for her but they do not offer insight nor understanding about the process itself, or the context of a woman's decision making. Because the majority of research about women's decision making, particularly in menopause, has been conducted quantitatively, women's own voices have not been heard.

The following chapter will describe the method of inquiry which was carried out in this study in order to document in a more personal way, the process which women embrace when they make decisions about this complex issue.

CHAPTER III

Methodology

The research question is influential in determining the method. Because the researcher was attempting to richly document a choicemaking process from the perspective of mid-life women, a qualitative approach was used to explore their experience of menopause and to illuminate the elements of the decision making process they embraced. More specifically, a grounded theory design was utilized to guide the research process in an attempt to answer the research question.

Grounded Theory

Grounded theory is a systematic research approach with the primary objective of developing theory that explains basic patterns common in human behavior (Chenitz, 1986). The principles of symbolic interactionism guide grounded theory research and suggest that through interaction with each other, individuals order their world by eliciting meanings in situations rather than simply reacting. This meaning is shared.

Grounded theory provides a means for eliciting these meanings and for describing the psychological and social processes that have been developed to assist people in making sense of their world. Grounded theory method allows the description of changes over time, and the descriptions of stages and phases within an experience (Morse, 1992; Morse & Field, 1995). From this perspective the researcher has the opportunity to understand behavior as the participants understand it, learn about their world, learn their interpretation of self in the interaction, and share their interpretations (Chenitz & Swanson, 1986; Glaser, 1978).

The principles of symbolic interactionism can be aptly applied to provide a context for the meaning women give to menopause in our society and subsequently the role of women as active participants in making choices and decisions that will have an impact on their well-being. For example, symbolic interactionists would argue that personal definitions of menopause will be formed from the meaning and consequence attributed to this experience by women. On the basis of this definition, beliefs that influence attitudes and interaction patterns are created. Thus, women encountering menopause will draw their attitudes and beliefs from the meaning they attribute to this experience in our world.

The objective of a grounded theory study is to discover a conceptual framework that explains the underlying social process of a phenomenon (Morse & Field, 1995). This specific study has attempted to explain the process women embrace in making choices and decisions about the management of their menopausal experience within the context of their personal resources, life circumstances, and mid-life issues.

This investigation, then, has focused on a group of women who are experiencing the menopausal transition. The utilization of a grounded theory approach has enabled me to gain an understanding of these women's perceptions and experiences about menopause and the process by which they determine the relevant and meaningful choices and decisions they make during this time in their lives. The desired result of this investigation is the development of a conceptual model that identifies key concepts and details the relationship between them in this decision making process.

Sampling

In qualitative research adequacy of the sample size is relative, a matter of judgment, based on the intended purposes of sampling and the intended qualitative product. Size of

the sample is not the critical issue. It is the quality of information obtained per sampling unit that has significance (Morse, 1986; Morse & Field, 1995; Strauss & Corbin, 1990). Sample size in qualitative research may refer to persons, but also to interviews and observations conducted or events sampled. People are central, but they enter qualitative studies primarily by virtue of having some direct and personal knowledge of some event that they are willing and able to communicate to others (Sandelowski, 1995).

To achieve the goal of obtaining the richest experiential data possible, grounded theory uses theoretical sampling to identify appropriate respondents (Gilgun, Daly, & Handel, 1992; Sandelowski, Davis, & Harris, 1989; Strauss & Corbin, 1990). Theoretical sampling is an ongoing process of data collection which is guided by the theory as it emerges (Baker, Wuest, & Stern, 1992). Initially the researcher may choose to interview participants with a broad, general knowledge of the topic or those who have undergone the experience and whose experience is considered to be typical. As the study progresses, the description is expanded with more specific information, and participants with that particular knowledge are deliberately sought. Finally, participants with atypical experiences are sought so that the entire range and breadth of the phenomenon may be understood (Morse, 1991).

Description of Participants

Eight women participated in this qualitative study. All had expressed an interest and a willingness to do so. They were English speaking and between the ages of 42 and 66. All had the ability to express and to share their thoughts, feelings and perceptions with me and were able to commit to a maximum of four hours of time for interviewing. Six of the women in the study had responded to the survey phase of the research project,

Choices & Changes: Mid-Life Women's Choicemaking About Menopausal Management research project (Kieren, Edwards, & Brook, 1996), and indicated an interest in participating in a second qualitative stage of this research about women's mid-life issues. The seventh woman had been previously known to the researcher, while the eighth woman was referred because of her specific menopausal experience.

My objective in selecting participants for this study was to ensure that the women would be representative of a range and a variety of menopausal experiences, and as a consequence would have made a variety of choices and decisions about how to manage their menopause. I reasoned that different menopausal experiences would give rise to individual choices and decisions and therefore individual strategies; each woman's individual strategy would reflect her personal decision making process.

Consistent with the purposive nature of theoretical sampling in grounded theory, I initiated the sampling process with a woman I had known, but whom I had not had contact with for many years. At the time I contacted her I was not aware of what her menopausal experience had been, however, I knew that she would be able to share her menopausal experience with me and that she could provide a rich description of her experience. In the first interview, I asked more general questions (please consult Appendix A). I wanted to know how this woman perceived menopause and what the nature of her experience had been thus far. I wanted to know if she had made a choice about how she would manage her menopause and what had influenced her to make such a choice.

Following that initial interview I began to contact women who had participated in the '*Choices & Changes*' research project. The second woman I interviewed was just

beginning menopause and as a result was at a very different stage in her choicemaking about menopause. Questions I asked in this interview were still general in nature but there was now a basis for comparison of the two women's experiences and choicemaking.

After the two initial participants were interviewed and their transcripts coded, the continued selection of women for the study was determined by the information I had obtained. I began to select participants because of their specific menopausal experience or because of a particular choice they had made. Selection of participants continued until my goal of obtaining rich data was achieved and the categories which were identified through data analysis were saturated; or in other words, no new information was being identified (Chenitz & Swanson, 1986). The result was that 8 women were interviewed.

An overview of the characteristics of the women in the study and their menopausal experience at the time of the study is provided in Table 3.1. Pseudonyms have been chosen to ensure the anonymity of the participants. What follows is a more personal description of these eight women.

Rebecca was a divorced mother of four children who ranged in age from 14 to 26. Her fourteen year old daughter still lived with her in her apartment. Debilitating rheumatoid arthritis, which severely affected the joints in her hands, had caused Rebecca to give up employment outside her home. She now worked on a part-time basis as a freelance writer and her income was supplemented by social assistance. Rebecca was 49 at the time of the interview. She believed she was menopausal because she had not menstruated in some time. Other than one instance when she had been concerned about an abnormally large amount of menstrual bleeding, Rebecca described a relatively trouble free menopause. She spoke of first noticing changes to her menstrual cycle and of having

Table 3.1

Characteristics of Participants

Name	Age at Time of Study	Marital Status	Level of Education	Status of Employment
Laura	54	Married 3 Children	Professional Degree(BScN)	Nursing related; Part-time
Rebecca	49	Divorced 4 Children	University Diploma (BA)	Writer; Social assistance
Susan	50	Married 3 Children	Professional Diploma (RN)	Nursing; Full-time
April	66	Divorced 5 Children	High School	Retired
Gina	51	Married 2 Children	University Diploma (BA)	Education; Full-time
Emma	55	Remarried 5 Children 2 Stepchildren	University Diploma (BA)	Writer; Full-time
Elizabeth	42	Married 3 Children	High School	Odd jobs; Part-time
Julia	61	Divorced Lesbian Relationship	Ph.D. Candidate	Student; Part-time research ass.

hot flashes which had not been troublesome for her. As she stated, "I think for once in my life my extremities were warm." Other changes which she described as also occurring during this time were a gain in weight around her hips and that her breasts had enlarged. Being more forgetful was something that she still noticed. Rebecca had chosen to manage her menopause using natural alternatives. She was extremely well informed about herbal therapies and used the local library and the Internet on a regular basis to keep her knowledge current.

At 54, Laura was a grandmother. She worked outside her home three days during the week in a job which drew on her nursing background. She lived in a large comfortable home with her husband who was a physician, and their youngest daughter. Laura's menopausal experience had also been uneventful. Not feeling cold as much as she used to and variations in her menstrual cycle were the only changes she described. Other than dietary changes and exercise, Laura had not felt the need for any other form of intervention although she was planning to discuss hormone therapy with her physician in the near future.

Julia was a PhD candidate who also worked as a research assistant 12 hours per week. She had been divorced for many years and was presently living in a lesbian relationship. None of her four adult children lived with her. Julia described hot flashes as the first change she noticed. Changes to her menstrual cycle had been largely uneventful with the exception of one instance when an unusually heavy menstrual flow had caused her to consult her physician. Julia had not chosen to manage her menopause with either hormone therapy or natural alternatives. She was conscious of eating well and was physically active.

Emma had been previously married. She was now in a second marriage which she described as happy and fulfilling. "...I think it's the most important thing in everything I do, and everything he does. We're still like two kids who pinch ourselves because we're together." Emma had previously worked as a medical stenographer and was now pursuing a career as a writer. At 30 Emma had undergone a vaginal hysterectomy; at 40 she experienced severe headaches which prompted her to see her physician who suggested she might be beginning early menopause. At the time of our interview Emma was 57. She no longer experienced the headaches which had initially prompted her to consult with her physician and she had discontinued hormone therapy. She seemed to be a woman who was content and happy, confident with who she was at this time in her life.

At the time of our interview, Elizabeth was 42. For the past two years she had been experiencing night sweats which she had found to be increasingly uncomfortable and interfered with her ability to sleep at night. After consulting with her physician she began to take medication to help her sleep but subsequently decided to discontinue this, and chose instead to exercise regularly and to bring a fan into the bedroom at night.

Elizabeth has suffered from chronic depression for some time and as a result, her primary concern about menopause was related to the possible emotional effects of this process. Elizabeth, her husband and two teenage daughters work together to support each other and to keep each other as emotionally healthy as possible. Elizabeth has become attuned to subtle changes in her body and participates as an equal partner with her physician to manage this chronic illness.

April has continued to take hormone therapy since she began to experience very severe hot flashes and night sweats approximately 15 years ago. She has attempted to stop

hormone therapy many times but finds the recurrence of hot flashes too uncomfortable. April is now retired and lives alone in a small townhouse which she owns. She was divorced many years ago and is estranged from all but one of her five children. According to April, money was always a concern for her. She appeared to be angry and bitter about events in her life.

At 38 years of age Gina began to experience changes to her menstrual cycle, then increasingly distressing hot flashes. Emotional changes including panic attacks, memory loss and depression followed. Neither she nor her physician recognized these changes as being related to menopause and consequently Gina was not able to manage these physical and emotional changes in a satisfactory manner through traditional medical practices. She subsequently found relief through alternative natural therapies. Gina is now 51. Both she and her husband are committed to demanding, but fulfilling professional careers. They both participate in an active lifestyle and pay attention to diet. Their two sons no longer live at home.

Susan supports her husband and two teenage sons working as a nurse in an active treatment hospital. Physical changes which included "the odd hot flush" and a gain in weight prompted her to question that she might be approaching menopause. Susan also began to experience depression at about the same time, but did not associate this change with menopause initially. Susan had suffered from postpartum depression following the birth of her children and now recognizes a link between her depression of a few years ago and changing hormonal levels associated with menopause. It took some time for Susan to understand what was happening to her, but with support from her friends and colleagues she was gradually able to able to make choices which allowed her to successfully manage

these physical and emotional changes. Susan chose to manage her menopause with hormone therapy and has been satisfied with this decision. She has made many lifestyle changes which also have contributed to the general sense of well-being that she now enjoys.

Data Collection

The primary means of data collection in this study was formal unstructured interviews. I chose this method of data collection so that the women would have the opportunity to share their experiences with me in a manner that was as relaxing as possible for both of us, and would be more conducive to allowing me to become acquainted with them as individuals and to understand them and their points of view. The interactive nature of this format also allowed me to clarify my perceptions with the woman being interviewed as well as to pursue particular topics of interest which arose out of the interview.

In the introduction to the interview, the purpose of the study and each woman's expected involvement was outlined in more detail. The confidential nature of research data was emphasized as well as the assurance that there were no right or wrong answers. Each woman read and provided their informed consent for participation in a written form (please refer to Appendix A).

Each initial interview session lasted approximately one to two hours. Interviews were conducted personally by the researcher either in a designated office in the Department of Human Ecology, or in the women's homes. All the interviews were audio tape recorded. The initial interviews were guided by a topical outline which introduced general themes with open-ended questions intended to focus the woman's thoughts but

still allow her to express herself openly and freely. The substance and direction of each interview varied with each woman's responses. Interviews later became more narrow in focus for specific information in order to substantiate relationships among the themes which were seen to be emerging. The nature of the emerging conceptual framework determined how to proceed. For an outline of the questions for the interviews refer to Appendix B.

Because concurrent data collection and analysis of data is vital to the success of grounded theory generation (Swanson, 1986), transcribing and analysis of the data took place as soon as possible following each interview. Each tape recorded interview was transcribed verbatim by a typist. Several duplicates of the transcription were made. To prevent loss, these copies were kept in my home in a locked filing cabinet to ensure the safety of the documents.

In addition to the interviews, process memos or field notes describing my observations about each woman's behaviors and interactions as well as my own behaviors in interaction with them were recorded following each interview. Each memo was labeled and dated. These data were transcribed by myself in conjunction with the corresponding interview data.

Demographic information was obtained from each woman at the end of the interview when a relationship with her was well established. Elements of the background information which were collected focused on personal characteristics such as her age and level of education. This information is included in Table 3.1. Each participant was assigned a code number to ensure retrieval of demographic data, process memos and specific interview content.

The purpose of collecting a variety of data from the participants was to maximize the range of data from which to interpret as fully as possible each woman's experience. By being able to consider each woman's experience as she related it to me in the interview within the context of her age and educational background, for example, as well as my own observations, made it possible to achieve a broader perspective and a more complete appreciation of the nature of her experience (Knafl & Breitmayer, 1991).

Data Analysis

In grounded theory research, sampling, data collection, analysis and the development of theoretical explanations occur simultaneously throughout the life of the research project (Chenitz & Swanson, 1986; Sandelowski, Davis, & Harris, 1989). This reflects the method identified by Glaser and Strauss (1967) as the constant comparative method of qualitative analysis. Concepts in a grounded theory come from the data and are formed through an analytical process that begins at the time of data collection and continues throughout the investigation.

Analysis of data began with the first interviews comparing for similarities and differences in the lives, perceptions and experiences of the women interviewed. Line by line analysis of the transcripts was carried out to look for indicators which would provide insight about the elements of the decision making process for these menopausal women. Open coding, or substantive coding, was used at this initial stage and was about breaking the data into small pieces reflecting the substance of what each woman said, using her own words and remaining true to the contextual meaning of her words and actions (Stern & Pyles, 1984; Strauss & Corbin, 1990). For example, a common element of each woman's story about her menopausal experience that began to become apparent was the

description of physical or emotional changes she noticed in her body. Open coding of this particular data at this stage of the analysis was about attaching a label or a code to the changes the women described.

Each transcript was read and sorted several times to find the best fit for the data until a category could be named and described with confidence. That is, codes were clustered according to observed similarities or dissimilarities of content, a category was formed and given an initial label. Sentences and paragraphs of the transcripts became the coding unit at this stage. Criteria for inclusion of data into a particular category were determined and specified. To illustrate this process, let me return to the above example. It became clear that there was a range and a variation in the physical and emotional changes the women experienced and in their reactions to the changes. There were changes women noticed but did not describe as causing them a great deal of distress, while other changes were found to be extremely uncomfortable and disruptive. Physical and emotional changes which appeared to be similar in nature were clustered together forming several categories. Women's reactions to the changes they experienced formed other categories.

A strategy which I employed throughout the analysis process which was useful in making decisions about the categories was to ask questions of the data. What does this statement indicate? Does it mean the same thing for this woman as it did for other women I have interviewed? Would any other category include similar statements or actions? The questioning process also helped me to focus on data I still needed to collect or verify, and consequently, often helped me to ask questions more precisely in subsequent interviews.

Further data collection and analysis produced other categories. Categories were compared and it become apparent how they too clustered and related to one another. This

process of categorizing, recategorizing and condensing the data moved the coding process to a more abstract level than the first stage of the process.

Each initial interview was reread and individual women were re-interviewed in order to verify or refute the relationships between the categories which began to be identified and to help me understand and explain this evolving process of decision making. The number of interviews that were conducted with each woman was determined by how receptive she was, the amount of information she was able to share and the contribution she was able to make to the emerging theory.

Data were reanalyzed for conditions under which concepts would emerge, as well as for the possible direction of the influence. As the categories and their properties became integrated, the focus moved to their interrelationships and a general theoretical framework began to develop.

At this point in the analysis it became important to expand and 'densify' the emerging framework. A strategy which I used at this stage of the analysis was to return to the literature. According to Stern, Allen, & Moxley (1984), literature, carefully scrutinized, helps expand the theory and relate it to other theories. Such a strategy helped to clarify and focus the need for further theoretical sampling in order to identify the properties of the main categories or variables and also to illuminate and clarify the evolving theoretical model.

Additional data at this point in the study were now collected in a selective manner for the specific purpose of developing the conceptual model and identifying the properties of the main categories. Through selective sampling, saturation of the categories began to occur (Stern, Allen & Moxley, 1984). Making linkages among the categories became the

focus when most of the categories had emerged, were developed and dense (Corbin, 1986). Once the categories had been built and linked, it was possible to pull the theory together around a central or core category.

Sketches or diagrams of the developing relationships between the categories were carried out continuously throughout the analysis and were an integral component of this process. The use of diagrams helped me to think very systematically about data--to clarify the properties of each category, to visualize how they were linked together and under what conditions. As the diagrams grew in complexity I was able to relate the data in increasingly complex ways. As this process continued, a visual conceptual model depicting the various stages and phases of the decision making process in menopause was created.

Throughout the process of coding and interpreting the data, analytic memos were maintained in order to formalize a written record of the analytical process. Writing memos provided a means of recording and preserving analytical ideas, hunches, abstractions and emerging hypotheses as they occurred (Stern & Pyles, 1985). It was important to capture these ideas and include a reference to the data that sparked them (Stern & Pyles, 1985). Because they showed the conceptual model developing step by step, a record of why and how decisions were made formulated an audit trail which contributed to the rigor of the investigation (Sandelowski, Davis, & Harris, 1989).

Memos were incorporated into the data analysis with each memo headed by the code or codes it described. In this way the ideas were retrievable because the memos could be shifted around to check the relationship with other codes. Irrelevant codes were discarded and core codes retained. The emerging conceptual model, therefore, was always

modifiable (Hutchison, 1993). As mentioned, diagrams as a visual representation of the analysis were also incorporated into the analytical process. Like memos, they grew in depth and integration as the theory grew.

Rigor

In qualitative research, any study and its findings are considered to be at least as much a reflection of the investigator as of the phenomenon being studied. Here lies the potential to enhance as well as the potential to threaten the credibility of a qualitative study.

Since grounded theory requires interpersonal interaction, it is important to be aware of personal preconceptions, personal biases, values and beliefs, and to understand their influence on the research (Hutchison, 1993). This is particularly important in qualitative research where the researcher is the major research instrument. A possible limitation of this study design which may have affected the credibility or the truth value of the study (Lincoln & Guba, 1989; Sandelowski, 1986), therefore, rested with myself as the researcher. The credibility of qualitative research may be enhanced, however, when investigators describe and interpret their own behaviors and experiences as researchers in relation to the behavior and experiences of the study's participants.

Being of a similar age to the women who participated in this study increased the likelihood of sharing many similar issues related to the research subject. At the time I joined the '*Choices and Changes*' research project I had not given a great deal of thought to my own menopause or how I would manage it. As I began to think about this, I became aware that I had the expectation I would have an untroubled menopause and that because it was a natural process, I would manage it through natural means. Then I began to read. I

was horrified to discover what might happen to me because of lower estrogen levels in my body. Hormone therapy was definitely the way to go. More reading. I was further horrified to discover what might happen to me because of taking hormone therapy. Suddenly I was facing the same dilemmas and choices that every woman I had talked to about menopause also seemed to be facing. Although I have not come to any firm conclusion about how I will manage my own menopause, I have become sensitive to my beliefs, values and attitudes about aging and about menopause, and also about my own process of making choices and decisions about this transition.

Of particular significance to the credibility or the truth value of the study, has been the growing awareness of the particular biases I brought to the research topic and to the study. I believed the medical profession to be pushing women to take hormone therapy over other alternatives, and as well attempting to dominate and control the management of this natural process for women. I came to realize I also believed that non-hormonal therapies would be better than synthetic hormones or hormone therapy, simply because they were natural and a natural product or intervention would, by its very nature, be better. As the study progressed, I became aware of the subconscious belief I held that women who chose hormone therapy over non-hormonal or natural therapies had not followed as thoughtful or as deliberative a process, but had in a sense, taken the easy way and "copped out."

The threat of becoming so enmeshed with the study that it is difficult to separate one's own experiences from those of the participants, can be offset by deliberately focusing on how the researcher influenced and was influenced by a participant (Sandelowski, 1986). A tool that I used throughout the study was a personal journal. I

used the journal to express and record my own personal reflections. The journal writing was effective in allowing me to consider, and to own, my attitudes, my beliefs, my values and my experiences so that the attitudes, beliefs, values and experiences of the women in the study belonged to them. Another strategy I used throughout the study to ensure objectivity was to collaborate on a regular basis with my research supervisor.

A qualitative study is credible when it presents such faithful descriptions or interpretations of a human experience that the people having that experience would immediately recognize it as their own. The findings fit with the experiences of others (Sandelowski, 1986). In order to achieve this goal, I shared the conceptual model which depicted my interpretation of decision making in menopause, with several women who had participated in the study. These women were able to confirm that the conceptual model did in fact reflect their own experience.

Another potential threat to the credibility of a study is that people who act as respondents in studies are frequently the most articulate and accessible. In other words, the nature of the participants themselves may influence the credibility of the study. As it was designed, it was possible that the women in this study would share these characteristics. In order to offset this potential limitation to the study, it was important to ensure that the study was well-grounded in the life experiences of the women who participated and that typical as well as atypical elements of their experiences were explored and validated. It was for this reason that the women who were selected to participate in the study came from a variety of backgrounds and were representative of many different life experiences.

In qualitative research, auditibility refers to the ability of another researcher to follow the "decision trail" of another researcher. Another researcher should arrive at the same or comparable conclusions given the same data and perspective as the original researcher (Lincoln & Guba, 1989). Auditibility was addressed through the following means in this study. Important decisions regarding actual strategies for conducting the study were documented on a continuing basis throughout the investigation by the use of process and analytical memos and diagrams. The coded transcriptions of the interviews with the women who participated in the study will be kept for an indefinite period of time and preserved so findings can be verified and confirmed by other researchers. The audiotaped interviews, however, will be destroyed following completion of the study.

In conclusion, grounded theory method was particularly suited for the purpose of this study which was to understand, from a woman's perspective, the process of making deliberate choices to manage the issues associated with the transition of menopause. More than this, it allowed the researcher to richly document the experience of real women making "real life" choices and decisions about a complex issue in a complex world.

The following chapter will record the findings of the study and in doing so, it is hoped, further understanding of how and why women make the decisions they do in order to manage their menopause.

CHAPTER IV

The Findings

I wrote in the introduction to this thesis that my impression of the experience of menopause for my friends and other women I had encountered was that each woman's experience was her own, unique to her and her life circumstances. That is still true. Now however, there is a depth to this knowing brought about by an awareness of the journey that led to the moment when eight women opened the door to their homes and I walked inside. When I left, I had been privileged to share a little of the personal journey these women had already traveled, with all its challenges and triumphs, and I learned that menopause was only a stop along the way.

What is the process that women embrace when they make choices about how they will manage the physical and emotional, as well as the spiritual and psychological changes they experience as they go through menopause? This chapter will present the themes which have characterized these women's experiences of making choices and decisions about menopause, and offer a beginning conceptual model that links these themes in a meaningful way.

In relating their stories to me, it became clear that the process of making choices about how to manage the specific challenges precipitated by menopause was a process within a greater process that could not be considered in isolation, separated from the larger context of what these women's lives had been and what they wanted their lives to become. It could not be separated from those they shared their lives with or the riches or lack of riches each may have encountered along the way.

It is for this reason that this discussion of the findings of women's decision making process in menopause cannot begin without first having an appreciation for this greater process which emerged as the core category in the model--the journey of achieving wholeness. It is by considering each woman's journey toward achieving wholeness in her life, that it is possible to give meaning to the key processes of decision making for women in menopause: *taking in; taking hold; knowing I'm right* and, *listening to my body again.*

The process of decision making in menopause, then, is diagrammed and presented as two major processes which are intricately interconnected with one another. Figure 4.1 diagrams the process of decision making in menopause within the greater process of achieving wholeness.

Figure 4.1: The process of decision making as a component of achieving wholeness.

The Journey to Achieving Wholeness

Each woman's journey to achieving wholeness in her life was revealed through the telling of personal stories of unique life events and circumstances which created the basis or the parameters for understanding how each woman had come to make her choices and decisions about menopause. Although there were many commonalties in the women's stories, each woman's journey to achieving wholeness in her life was unique to her, created by circumstances and events. Although each woman referred to this process in her own way--to be complete, to achieve balance, to be in control, to feel fulfilled, to feel whole--the meaning or the essence of this larger goal for all women was the same. It was reflected in their beliefs about being healthy, about becoming older, about menopause itself.

As Emma relates to us:

> To me menopause wasn't anything I was terribly concerned about. I didn't have any problems about the whole thing. It meant a whole avenue opening up and the freedom to pursue a career and all. It was a very exciting time in my life at the time it happened. Not because it happened, but at the time it happened.

For Susan:

> Menopause means a changing in life--that I'm approaching fifty. I never really thought about getting old, because I never slow down. I just keep going.
>
> I think it's just another step in our life, and I'm really looking forward to that other point that I can have other freedoms and do other things. It's just moving on and just changing things in your life--giving up certain things and stepping into another phase.

In Laura's words:

> There's so many markers in your life, that you can't get depressed about

> markers. You know, I mean you have a marker every time you change a job, when your children leave home, or when you stop belonging to some group, you stop volunteering and you're not going to be a member of that group anymore. Those are all markers, they're all changes. You're not going back, so the key I think is to move ahead.

I would like to relate some of Susan's story to illustrate how the process of making choices and decisions about menopause for her was deeply interrelated with the greater process of achieving a sense of wholeness in her life; how her choices and decisions could not be separated from the larger context of what else she was experiencing.

Susan began to experience physical and emotional changes associated with menopause at a time when other complex life events were causing her to examine who she was and how she was living her life. As an operating room nurse who usually assumed a leadership role Susan was used to people depending on her. She assumed responsibility and control in her personal life as well--managing a household and organizing the lives of her three children and her husband. As she stated, "I felt all my life that if I had control, then I could make things good or bad, according to me."

But Susan's life was changing and she was able to provide a rich description of these changes:

> Life has changed a lot. The kids are getting older. My work situation is changing. My husband is going through crises too--losing our company--and alcoholism became a primary thing about five years ago. Also about that time, I put on a lot of weight. I wasn't pleased with the way I looked. I was finding that I didn't have very much self-worth. I was crying all the time. I think I cried for two years before I went for help. I was losing it all.

For Susan, moving toward wholeness in her life was about regaining control of her body both physically and emotionally; about reclaiming control of her own life.

Susan's body was changing--she attributed her weight gain and depression to changing hormonal levels--but so was life around her. The choices she made in order to manage the changes her body was undergoing were interrelated with the choices she decided to make because of other life events that were occurring at the same time. The choices she made and the outcome of the choices were self-reinforcing.

Participation in Alanon as well as a weight loss support group helped Susan to cope with her depression. As she began to exercise, she began to feel better about herself. The support of others through Alanon and the weight loss group helped her to examine her interactions with those whom she shared her life. As Susan began to regain control of her own life she learned that she didn't need to control the lives of her husband and young adult children. She began to live her life according to her own standards and values.

In Susan's words:

> Since I've sort of let other people live their own lives, I have a lot more time to live my own life. So, I have time to exercise and do things I never had time for before because I was so worried about getting home to drive this person here, and this boy there, and this girl here, and pick up from swimming, and drive to hockey, and now I don't worry about that. I don't have to control anymore. I changed the focus--even the focus of my own life. It's changed my whole life.

Another woman, Gina, described the journey toward wholeness in this way:

> I think it's perfectly true that, or perfectly acceptable to me that, there are times when your life is way out of balance, but that's how it has to be, and that's how it should be. Whether it's because of a particular crisis or whether it's because you have a whole bunch of little kids. I mean, you want balance in your life. But, a sense of being whole and functioning, a sense that I am doing many things that I want to do or I feel right about--this is a very personal sense of--sense of wholeness.

Despite the disruption to her daily life that menopausal changes caused, each woman spoke clearly and emphatically that menopause was a natural process she would

get through, an inevitable life experience. Menopause wasn't a single event, an entity unto itself. It was viewed within the context of what it meant to these women to realize they were growing older, that their lives were changing, and that they faced the challenge of making whatever lay ahead for them as rich and rewarding as possible.

I came to recognize that the choices and decisions these women made had meaning for them, not only as a means to managing menopausal changes, but also because of their desire to live their lives according to their own standards and values. This was not a linear, static process but cyclical and self-reinforcing in nature, as was the nature of the process of making choices and decisions about menopause.

The Process of Decision Making in Menopause

Taking In

The impetus for the beginning of decision making about menopause for each woman was dependent upon two interrelated components: listening to my body and finding meaning. Each woman first had to recognize or perceive that a change was occurring within her body and she had to give meaning to the change. That is, each woman had to recognize that the physical and emotional changes she was experiencing were related to menopause and she had to determine what these changes would mean to her within the context of her personal beliefs and her life circumstances. Figure 4.2 diagrams the interrelationship between these two components of "taking in."

Listening to My Body

The nature of each woman's physical and emotional changes, and as a consequence her ability to be aware of the changes her body was undergoing was unique

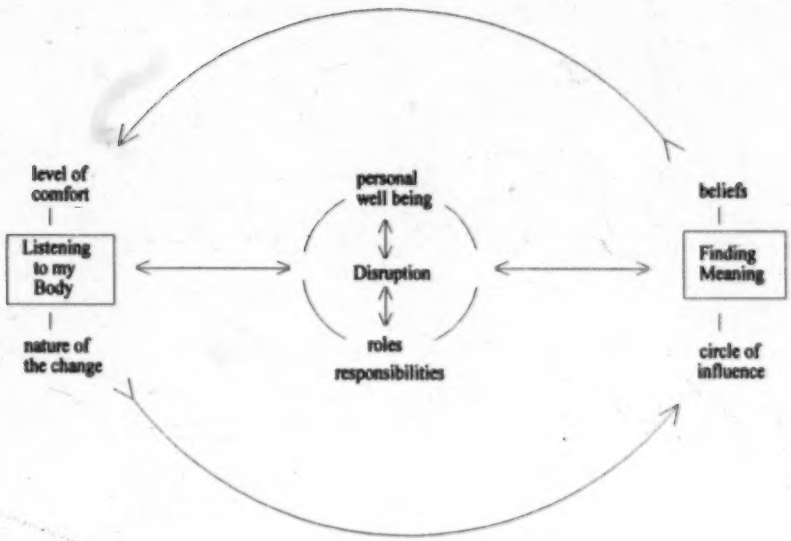

Figure 4.2. The process of Taking In: The relationship between listening to my body and giving meaning to the change.

to each woman. Embedded in this process, certainly, was each woman's genetic make-up over which she had no control, and yet, which dictated the nature of the physiological and psychological processes she would experience.

Some women experienced a subtle, growing awareness that something was not the same, for others the changes were more intense. The nature of Julia and Rebecca's physical changes, for example, were illustrative of the kind of experience where the changes occurred over a period of time, and although noticeable, did not become a major focus in their daily lives. Julia began to be aware of variation in her menstrual cycle and

that she sometimes felt warmer than usual during the day and also at night. For her, these changes had seemed to appear slowly and diminish in much the same way.

> I went with my partner and two of my children to the Soviet Union for about six weeks on a trip, and I think it was at that point that my periods stopped entirely, and I didn't really think about them until afterwards, and my daughter said mom, you finished your menopause. You haven't had a period. And I went, oh okay. So that was kind of how it went. And the hot flashes went on a little longer, but that was it. I mean--and the hot flashes weren't terrible--so it really wasn't--I didn't notice anything else much.

Rebecca's experience was not entirely the same as Julia's, however, her reaction to the changes was similar in that she seemed to incorporate them into a new definition of how her body could be expected to behave:

> My period had changed. It was no longer the same. There was just a lot of weird little things happening. Oh one thing I noticed that really surprised me was that my breasts got bigger, just out of the blue got bigger. But the thing is, I also noticed that I was gaining thickness through the waist area and hip area, you know. I mean I never really had hips, but all of a sudden I had hips. I don't know if I can pinpoint any things that were happening per se. It was just a general feeling.
>
> I'm positive I had hot flashes. I've been very lucky that they haven't been really bothersome. Yeah, they've been there, you know, and after the first one, it's oh was that a hot flush? Oh interesting.

In comparison, Emma, April and Gina experienced changes which they described as becoming extremely uncomfortable for them.

As Emma described:

> When I was 40, I started having some very severe headaches. They would disturb me at work. I was sort of embarked on a pretty good career, and I was finding that they were bothering me at work--they were severe. Enough for me to go to a doctor.

In April's case:

> I was just getting really bad [hot flushes]. I thought it might be just the heat but it was worse than the heat, you know--very uncomfortable, but my

> hot flushes are worse than most people's. Mine are severe. I couldn't--you know, I'd sweat and everything at night. I couldn't sleep.

Gina too described severe and frightening changes:

> It was horrendous. Sometimes skipped periods and so on, but that didn't bother me at all. From that point, then I started to experience the hot flashes, and they would happen really, really frequently--and that means like several times in a row, and then I started to feel very frightened for no reason--just a panic attack, which would always be followed by a hot flash. It just kept getting more and more difficult.

Table 4.1 provides an overview of the physical and emotional changes each of the eight women in the study described as well as other medical conditions they have experienced.

Giving meaning to the change

As mentioned earlier, the impetus for the beginning of decision making for each woman was dependent upon two interrelated components. First she had to listen to the physical and emotional messages of her body and recognize that a change was occurring. She then had to determine what meaning she would attribute to these changes.

A key theme that emerged because of its significance in influencing the meaning that each woman chose to give to the changes she recognized as occurring, was how disruptive she perceived these changes to be to her daily life and to her general well-being. A key factor here was her physical and emotional comfort as a result of the changes. In the recent passages, both Julia and Rebecca talked about realizing they were experiencing physical changes, but neither spoke of the changes as being so bothersome to them that they interfered with their daily lives. Laura's experience had been the same, and while Elizabeth found that she was somewhat uncomfortable during the night, she was able to manage. In contrast, Emma's headaches were severe enough to be

Table 4.1

Physical and Emotional Changes/Other Medical Conditions

Name	Changes Associated with Menopause	Other Changes Noticed	Other Medical Conditions
Laura	Changes to menstrual cycle	Weight gain	
Rebecca	Changes to menstrual cycle; hot flashes	Change in body shape; forgetfulness	Rheumatoid arthritis
Susan	Changes to menstrual cycle; hot flashes	Depression; weight gain	Elevated cholesterol level
April	Hot flashes		Osteoarthritis; nephrectomy
Gina	Hot flashes; changes to menstrual cycle	Panic attacks; depression; forgetfulness	
Emma	Headaches		Hysterectomy; cancer of the thyroid gland
Elizabeth	Night sweats	Forgetfulness	Chronic depression; endometriosis; PMS
Julia	Changes to menstrual cycle; hot flashes	Weight gain	Thyroidectomy

interfering with her ability to carry out her work; April perceived her hot flashes to be "worse than most people's" and they were interrupting her sleep at night.

It is important to appreciate that level of comfort should be broadly interpreted to include emotional comfort as well. For both Susan and Gina the emotional distress they experienced was also painful for them.

As Susan described:

> I was in tears all the time. I think I cried for two years before I went for help. I was crying all the time. I'd go to church and cry. If someone would speak to me, I'd cry, and so I knew I was in trouble. I needed something.

As we know, Gina experienced changes to her menstrual cycle and hot flashes, but emotional changes also caused her a great deal of distress and interfered with events in her daily life.

> I was getting really depressed, and I couldn't concentrate, I couldn't remember stuff, and just all of those kinds of things that you read--you don't really even find in the literature, and I didn't associate at first the panic, and the depression, and all of those kinds of things with menopause either. I really didn't know what was happening, and I blamed it on work stress, and that went on for several years.

The roles and responsibilities each woman assumed in other spheres of her life at the time of menopause was another key factor which influenced the meaning women gave to the changes they experienced. Whether or not the changes interfered with her ability to carry out these responsibilities was also related to how disruptive she perceived the changes to be. In Emma's case, she was at a time in her life when she was actively pursuing her career. As she explained, "I was sort of embarked on a pretty good career, and I was finding that they [headaches] were bothering me at work."

As another example, April was a single mother who was responsible for the care of her five children as well as frail, aging parents who also lived with her. Having to cope with severe hot flashes which interfered with her sleep affected her ability to manage the responsibilities she assumed as a consequence of her role as provider and caregiver to her children and parents.

As April explained:

> I have five children. I had no time to do a lot of reading about these things ahead of time, and I had my parents--and they kept me pretty busy, you know, because my mother could hardly see, and my dad was getting pretty old, and he was kind of half senile, and he didn't remember who mom was half of the time, and who I was half of the time.

Each of the eight women in the study were surrounded by people with whom they shared their lives. As members of a family and a community, they experienced relationships as someone's daughter, someone's mother, someone's partner, someone's friend or someone's colleague. What became apparent in talking to these eight women was the importance of having resources and experiences to help them understand or make sense of the changes they were going through, in a sense offer a frame of reference against which they could compare their own experience. People, particularly other women, were central to this "circle of influence," but so too were other resources that each woman was able to access and draw upon which would enable her to understand the changes she was experiencing. This circle of influence was another key theme which emerged as a component of a woman's ability to attribute meaning to the physical and emotional changes of menopause.

A most significant source of influence which could offer a frame of reference came from the relationships each woman had with other women and the ability of these

women to understand and appreciate what she was going through. Although it did not define their own experience, many of the women in the study were aware of the nature of their mother's experience of menopause. This knowledge of their mothers' experience appeared to contribute to their understanding of their own experience to a small degree. Other relationships were also responsible for providing this frame of reference, including other family members and colleagues.

Julia for example, had a community of women friends who were experiencing menopausal changes at the same time she was undergoing her own.

> I talk a lot to my friends about things, you know, processes. I guess we all talk to each other about processes we're going through. Well I guess when I started getting hot flashes and also other people had symptoms, and when things start happening, you kind of talk about them. I mean when I was bringing up kids, I used to talk to other mothers. You talk to other people who are going through the same.

Laura too spoke of talking with her friends and sharing their experiences.

> It's funny because I was having coffee with a couple of friends this morning, and they were talking about being menopausal and how they felt that this irritability that one of them was complaining about is definitely a part of menopause. She didn't always used to be so irritable, and they were talking about St. John's Wort, and they were talking about Evening Primrose Oil, you know, and what does it do for you.

Elizabeth had experienced menopausal changes at an earlier age. Because of this and the fact that she was also younger than most of her friends, she did not consider them to be a source of influence for her at the time we spoke together. Instead Elizabeth was able to rely on her family.

> I've talked to my sisters about it a bit--actually probably one sister more than the other. And she probably has a lot of the same kind of thoughts. It's been helpful. Just to know that--it's like anything, you know. To know someone else's got it or going through it or--you know--the same idea. Or will be going through it or sharing it.

> You know, my husband's really supportive. He lets me know if he sees any kind of changes in me or finds I have been moody lately. You know, he'll tell me, 'You don't seem like yourself. You seem that you've been down for the last few days. Are you okay? Or, what happened?' And I can appreciate that from him or from my children because my children will tell me the same sort of thing. 'You know, mom, you haven't been as cheerful as you usually are,' or whatever. And I, I'll listen to that. And I'll take it as maybe something I should be aware of that I'm doing or not doing.

For Susan, the women in her work setting have been of primary importance in helping her to understand her physical and emotional changes, beginning with her supervisor who helped her to recognize that she needed emotional support to deal with her depression, and on an ongoing basis, her co-workers.

Gina also had women friends in her life. However, they were not able to provide her with a frame of reference to understand and make meaning of the physical and emotional changes she was undergoing. I think Gina's inability to find a "community of women" who could help her to understand her menopausal changes, in contrast to the women mentioned above, illustrates how different a woman's experience may be when she is not able to access other women as a resource.

If we remember Gina's experience, she began to be aware of physical and emotional changes occurring in her body at 38--an early age to begin menopause. None of her friends were encountering similar changes at this time. As a consequence, Gina did not have access to the same community of women who were able to share their experience and in so doing, help Gina to understand her own. The timing and the nature of the changes Gina experienced may also have been factors here. Because of the ages of Gina and her friends, menopause was not as likely to be a topic for conversation. As well, Gina admits that depression was not something she perceived that people felt comfortable

talking about openly and neither did she feel comfortable talking about it herself. The following passage, I think, suggests the isolation that Gina felt.

> I couldn't get anybody to pay attention--there was nobody to tell or you tell people and nobody knew what to do with it, and you wouldn't tell that to very many people [panic attacks and depression].

Even now, many years later, Gina still perceives that menopause is not a subject she is able to talk about with her friends in large part because her friends are not experiencing the same intensity of changes that defined Gina's experience. Because of this they are not a significant resource in her circle of influence.

> They [friends] don't seem to be having major difficulties, so it's still not something that gets much talked about. I have a good friend who's a nurse, and she's a good listener, but I don't think still that it's something that is talked about very much--but I was ahead of a lot of my friends. It's not something people talk about. Nobody talks about this, and that's where the--networks--they really work well. Who have you gone to and what have you done.

Another dimension of each woman's circle of influence which contributed to the meaning she attached to menopausal changes was her past experiences in coming to terms with other health issues. Having to deal with other health issues in her life provided her with a frame of reference from which to consider what meaning she would attribute to the changes which occurred in association with menopause. For Emma this had been dealing with cancer of her thyroid gland. As her words indicated, this experience had provided her with some perspective from which to make sense and meaning of her menopausal changes.

> I had cancer which I think changes a person completely. I mean, I think you approach life--at least I've approached life very differently--understanding what it meant and its fragility. And I think once you've had a major thing like that--my children were still young, so I had all those

> concerns--menopause seemed like small potatoes compared to that, to be honest.

The same was true for April:

> I wasn't worried like some people were [about menopause]. I mean, I knew I had to go through with it. I worried more about my kidney than I did about my menopause.

Elizabeth struggled on an ongoing basis with premenstrual syndrome and chronic depression. The possibility of emotional changes occurring in association with menopause was a concern for her because of her experience with these illnesses.

> It scares me a little bit [menopause]. Not the physical aspect, but the emotional and the mental kind of side of it, I think, scares me more than anything. What kind of mental changes can come with it because of the change in the hormones. Do you know what I mean? If there's depression with it, that that sort of thing. That concerns me a lot. I've dealt with all of that, with depression. And that is a real big thing for me.

Although menopause was considered to be a natural transition by all the women who participated in the study, it was also an event which brought attention to the fact that they were getting older, the recognition that one phase of their lives was ending while another was beginning. Coming to terms with the physical and emotional changes associated with menopause and attaching meaning to them was intricately intertwined with each woman's personal beliefs about menopause and aging, as well as looking forward to the next phase of their lives. As a result personal beliefs also emerged as an influence and a common theme in the process of each woman's decision making. Just as physical and emotional changes required that each woman listen to her body, her personal beliefs also required that she listen to the spiritual messages of her body.

There was an element of loss associated with this process. Some women spoke about realizing they were moving beyond childbearing and that that part of their lives had

come to an end. Others spoke about coming to the realization that getting older meant changes to their bodies including gaining weight, graying hair, and wrinkles. However, there was also the anticipation of moving forward.

Laura spoke about menopause as a transition point of her past and future.

> It's a stage of life [childbearing] that's finished but I don't want to give it so much importance in my life that it has to hold me back from what I want to do.

She shared more thoughts about growing older.

> It's funny. I was saying to my husband last week that I don't like looking in the mirror because I look much older, and he said, you don't look older to me, you look great. I like it the way you are. And he's looking straight at me (laughs), but I mean, he's very encouraging, he's very positive, but, yeah, it's frustrating. I'm putting on weight, and that's frustrating. I'm not running any faster on the squash court, so that's frustrating. Like you're not going to get a whole lot better, and you know, you see wrinkles, you see your hair turning gray, and you see yourself and you, think, and that's not the most fun thing. It was easy to imagine getting older, but I didn't think it would be much of a change. Things may not have been wonderful before, but they were better than they are now. But I think you get to a stage where you say, it doesn't matter. Stay healthy and that part doesn't matter. But right now it matters of course.

Susan's words also reflected the realization that beginning menopause made her more aware of getting older. Just as she had to find meaning for the physical and emotional changes she had experienced with menopause, her words suggest that she also had to come to terms with what menopause would mean to her.

> It's inevitable [menopause]. You don't think about it until it gets close to you and you have to face it. I think it made me feel that I was getting older. I never really thought about ever getting old till I thought of that. I think that's a big thing right now--look young and stay young and feel young. But, I guess I'm coming around to acceptance. I guess I probably went through a denial. Like I thought it's not happening right now. It's just, just something else. I guess it's an acceptance, acceptance of you getting older and things are going to change.

And for Elizabeth:

> It's [menopause] a sign of growing older. I don't think that anybody really likes the idea that they're growing older. I'm not terribly afraid of growing older. It's just that, it's a vivid sign--to really make you aware of the fact that you are growing older.

The first phase of the decision making process in menopause is an intricately woven tapestry which involves listening to the physical, emotional and spiritual messages that a woman's body conveys to her. In order to move forward each woman in her own way must make meaning of what it is her body tells her. Physical or emotional changes may initiate the process, but the implications of these changes must be considered within the context of each woman's personal beliefs and life circumstances which include her roles and responsibilities and the resources available to her within her circle of influence. It is the interrelationship between these components of the process which influenced the meaning women attributed to physical and emotional changes and provided the context, or the parameters for moving forward to the next phase of decision making.

Taking Hold

Moving toward the next phase in the process of decision making was about taking hold of her body once again--to move forward--to regain control. It had taken each of the women a period of time to reach this place.

It is Gina's words, I think, that best capture the essence of this process.

> This was just something that was going to pass by in truth [menopause]--but then there's the point I suppose, that you decide you have to take control of it because it's starting to take over your life. It's a sense in which you feel like your body is actually betraying you--that this is not something you're willing to accept as normal, or yeah, as normal, and it's not acceptable.

Laura described her experience. Her words offered insight into another dimension of this process--a change in perception or in meaning, from something intangible, someone else's experience, to becoming something that was real for her.

> It never seemed very personal before. You know, before you're always reading, hearing women talking about how terrible they feel. Why aren't you reading this book? And you sort of say, why should I? It just didn't seem like there was anything that you could do, but now it does.

The central components of the first phase of decision making, listening to her body and making meaning of the physical, emotional and spiritual messages, form the foundation for moving forward in the second phase. As the meaning of the changes for each woman was a reflection of her personal beliefs and circumstances, how she chose to move forward and take hold was also a reflection of her beliefs and circumstances. Consequently the themes of level of comfort, personal beliefs and circle of influence are once again integral components of each woman's personal experience in the next phase of decision making.

A woman's level of comfort as a result of the changes she experienced was a central theme which emerged again in the second phase of the decision making process. As in the first phase, level of comfort was related to the nature of the changes and the degree of disruption a woman experienced in her daily life as a result. That is, her ability to carry out her responsibilities as prescribed by the roles she assumed in relation to family, career and community.

In the first phase, level of comfort influenced the meaning a woman would attribute to menopausal changes and in the second phase, her level of comfort influenced the manner in which she would act to regain control of her body and the nature of the

interventions she would choose. Those women who perceived the nature of the changes to be uncomfortable and disruptive were motivated to seek outside help in order to regain control over their bodies and their lives. Help was sought most often from their physician and hormone therapy was most often the alternative that was prescribed. Those women who perceived the changes to be manageable for them were likely to have consulted with their physician in order to confirm for themselves that they were in fact beginning menopause. They most often chose alternative therapies or specific lifestyle changes such as diet and exercise for example. Table 4.2 describes the interventions chosen by the eight women.

Women such as Emma, Gina and April seemed to have a sense of urgency because of the discomfort and disruption caused by the changes they experienced. They consulted with their physicians because of physical and emotional changes they didn't understand and to find relief for their discomfort. Other women such as Laura, Rebecca and Julia, who experienced more subtle and less disruptive menopausal changes, were less motivated to act right away. They were able to take more time to make a choice. At the time of my discussion with Laura, for example, she had not thought about any interventions to manage her menopause because, as she stated, "I haven't had any symptoms." Gina's words, in contrast, reflect a sense of urgency which motivated her to move forward and take control.

> I mean when this whole thing got out of hand, I think getting control of the symptoms was the key factor, and anything that would work almost was going to be just fine and dandy. It's like you have to stop the bleeding before you can treat some of the other problems. So in the beginning, probably getting that under control was the key thing.

Table 4.2

Chosen Interventions

Name	Initial Intervention (s) Chosen	Subsequent Intervention (s) Chosen
Laura	Regular Exercise; diet changes	Considering hormone therapy; calcium supplement
Rebecca	Hormone therapy for 1 month to treat heavy menstrual flow; herbs and vitamins; diet; calcium supplement	Continuing alternate therapies; exercise program
Susan	Hormone therapy; cholesterol lowering medication; exercise; vitamin and calcium supplement; diet	Continuing hormone therapy and other interventions
April	Hormone therapy; diet	Considering discontinuing hormone therapy
Gina	Herbs; elimination of caffeine, red meat, sugar and alcohol from diet	Hormone therapy
Emma	Hormone therapy ; diet	Discontinued hormone therapy; Calcium supplement; diet
Elizabeth	Regular exercise Birth control pills	Has not changed regimen
Julia	Diet and regular exercise	Has not changed regimen

It is interesting to note that both Rebecca and Julia, who experienced only subtle menopausal changes which caused little disruption in their lives, were prompted to consult with their physicians when they experienced excessive menstrual bleeding which they didn't understand and which caused them both some anxiety. It is this experience, I think, which clearly demonstrates the relationship between the nature of menopausal changes a woman experiences, her level of comfort as a result of the changes, her ability to understand what is happening to her, and her motivation to take control of the situation.

In the first phase of the decision making process, having a circle of influence was an integral component of a woman's ability to attach meaning to the changes she was experiencing. In the second phase of the decision making process this circle of influence impacted upon the nature of the interventions she would choose to manage these changes. Once again a community of women was an important resource. Those women who were able to understand the menopausal changes they were experiencing by sharing information and their experiences with other women were also able to discuss possible alternatives to manage those changes.

Once again another key resource within her circle of influence was a woman's physician. April, Gina, Emma and Elizabeth sought out their physicians. For April, Emma and Elizabeth these people were instrumental in helping them to make a choice as to the manner in which they would manage changes which they described as being uncomfortable and disruptive for them.

It is Gina's experience that once again illustrates the consequences of not being able to move forward and take hold of physical and emotional changes because there was

no resource within her circle of influence to help her finding meaning for the changes or a helpful intervention. Her physician was unable to recognize that the physical and emotional changes Gina was experiencing were related to menopause and as a consequence he was not able to prescribe a therapy which would help her. It is Gina's experience which also illustrates the importance of other resources as a component of the circle of influence. As Gina relates to us:

> There was no community experience to go on, and nothing that I could find [in the literature], just in the ordinary, everyday things that you would pick up on menopause. There was nothing about severe symptoms that I was having.

Past experience in dealing with other health issues was also a significant influence in choosing options to manage menopause. Rebecca's experience with traditional medical practices to manage childbirth and her arthritis led her to question their appropriateness for her. Over a long period of time, she was influenced to seek other ways to manage her health.

> I had the attitude that doctors knew everything, but then I was in hospital a year before my son was born, pregnant, hemorrhaging. I lost my baby because he was stillborn, and it wasn't necessary because they made a mistake, and I started questioning.
>
> I will admit, I'm like everyone else, if there's an instant cure, I would like to try it. And yet I know because I have arthritis, because I've been dealing with that for a long time, and I've dealt with some of the conventional therapies for that, and found that they are very--I don't know, they made me sicker. And that's one of the reasons I finally said, enough of this noise, I know better. I've used herbal therapies before, I've used alternative therapies before, I'm going to see what's out there to deal with the arthritis. So at the time I had menopause, I was already looking more into the herbal stuff to deal with my arthritis.

In taking hold, the consideration of current as well as possible health issues also impacted the choices women made. For example, Susan's awareness of her high

cholesterol level and her father's recent stroke influenced her decision to begin hormone therapy. Awareness of her family's history of osteoporosis had influenced Rebecca to begin a formal exercise program and to ensure that she was getting enough calcium.

At the time of our discussion, Laura was beginning to consider taking hormone therapy. She had considered her present health status as well as her vulnerability to other health problems in coming to this decision. Her words reflect possible health issues other women in the study also spoke of when they considered their choices for how they would manage their menopause.

> Well, you hear about the pros and the cons of hormone replacement therapy. You hear that it may increase the risk of breast cancer, but I know of no breast cancer in my family, so I'm not terribly worried. I hear that it potentially prevents heart disease, and if I thought that was all it would do, I'd probably wait another 10 to 15 years before I start taking it. In the meantime my heart is pretty healthy and I am pretty active. Then you hear about the other benefits of hormone therapy, like lubrication, libido, tissue health, you know, all those things. [Osteoporosis] would be a consideration but I'm not an osteoporosis-type to start with and I do a lot of weight bearing exercise. So I don't have any particular concerns.

Coming to terms with the physical and emotional changes associated with menopause and attaching meaning to them was intricately intertwined with each woman's personal beliefs about menopause and aging. That each woman's personal beliefs also influenced the manner in which she chose to move forward in the second phase of the decision making process, was reflected in the words of the following women. Their words also suggest the influence generated by their interaction with others in their immediate community and by societal or cultural beliefs about menopause.

Laura described conflict between what she felt pressured to do and what she

believed about her body and aging naturally.

> I think there's some medical reasons to take it [hormone therapy]. I guess what I've been struggling with for quite awhile is the idea that hormone therapy has become a fad. Everybody thinks they have to take it. It's the thing you're supposed to do, and so, I have to say, what good reason is there to do it? Is it natural to take these hormones, you know, is this what nature meant us to do, is to replace the [estrogen]? If your body is comfortable, and you're healthy, and nothing is wrong, why take them at all?

Julia believed in her body's ability to look after itself and seemed to honor this belief by not interfering with her body unless it was warranted. Her words also illustrated a link between what she believed about her body and how she chose to manage her menopause.

> I sort of had this feeling that my body would probably look after itself quite well because it's kind of designed to do that. So maybe if it isn't doing anything awful [I shouldn't] worry about it. I'm not really a medical intervention person unless it's, unless I'm ill. So I didn't want to go on hormones. I think I'd think of just about anything not to go on hormones.
>
> I also remember saying, you know, I don't think it's so bad to die when you're supposed to die and not live forever. So if my bones get, you know, if things happen, if our bodies do kind of break down and we do die, that's not such a bad thing. I know some people of my mother's generation that keep on saying, 'I've been around too long, I don't want to be here anymore.' It's sad.

Rebecca's beliefs about menopause seem to have been influenced by knowledge of cultures where menopause is viewed positively unlike our Western culture where she perceived that it was viewed as an illness. Her words suggested that for her there was a relationship between one's beliefs about menopause and a woman's menopausal experience. These beliefs influenced how she chose to manage this transition.

> I think that's why menopause hasn't been a big problem [for me], you know, because there's an awful lot of cultures where menopause is viewed as a positive time, and it's our western culture that has turned it into

> almost a disease, and it's not. And I think, it's up here [in your mind]. It's how we approach it ourselves, and if we approach it as a disease or an illness, then it's going to be a disease or an illness. And if we also want instant relief and turn to conventional therapies, we should be informed. There's other things that work if you're willing to give them the time.

Emma also believed menopause to be a natural transition. Her words show us that having such a belief does not always mean a woman will choose a natural or a non-hormonal alternative to manage menopausal changes. She made a succinct point when she stated:

> I see childbirth as very natural too, but that doesn't stop me from having medication during labor--if that's an explanation.

Each woman's choices and decisions about how she would move forward came about as the result of a thoughtful, rational process. There was a formal, clearly defined component of this process where they weighed the advantages and disadvantages of an alternative, consulted reading material and collaborated with others before making a decision. Just as importantly there was an emotional or even a spiritual component they incorporated into their decision making. It was perhaps less well defined but it was a credible and necessary part of the process for them.

Emma and Elizabeth both described a formal process when they made a decision. Emma described herself as first being impulsive when she approached a decision, but then always re-visiting the initial decision by doing "some good studying" or discussing the decision with her husband. She might change her mind if she thought it was necessary.

> I do go through the [problem solving] stages. I know when my husband said let's buy the house, for example, I said I'm going to take a walk--that was my first statement. And then I took a walk by the sea shore, and I was processing at the time. So when I am impulsive, I also do use [a strategy].

> You know, what's the worst thing that could happen if [I] did this? Can we afford it? How much is it? I mean, [I] go through all these things before [I] do it. And I often think that precognition has some bearing on it too. So many of the decisions we make, we have some idea that they're going to face us. You know, maybe you don't want to say it, I might be menopausal, but it's there, and it's processing.

Emma also described an emotional or a spiritual component to her decision making.

> [I] take a lot of information and a lot of variables and a lot of pros and cons and work them through [in my mind. Then [I] need to, just put them away, and I pray. I guess what I pray for is just discernment, the discernment and wisdom and the ability to accept the consequences. The strength to accept the consequences. I think that sometimes if I take the time to do that, that's exactly what happens.

Elizabeth too gives us a very clear example of using a formal strategy to decide whether or not she and her husband should sell their house and buy a new one. Her words also reflected an emotional component to her decision making process that was very important to her.

> I'd really a lot of concerns about it [selling the house] and made a list of the pros and cons. And I think basically, even though the pros of buying a new house outweighed the cons, emotionally when it came down to it, it was really hard for us to decide to actually leave. So the emotional aspect kind of won out in this case. I think if the pros [out]weighed [the cons] too much, then you would have to work more with that. But there's always that emotional side of things, whether it feels right or not to do something and I've actually put off doing something, not because I've wanted to procrastinate, but because the feeling wasn't right.

Although not a formal strategy in a traditional sense, Julia describes a process that is effective for her. It reflects the experience of many of the other women.

> Usually I sort of think things out when I'm asleep and wake up in the morning and I know the answer. I don't know how I come by it, but that keeps happening. Or if I'm really upset, I'll wake up in the middle of the night and stew about it, because obviously whatever process that works things out for me, if that process can't cope, then I wake up in the middle

> of the night and start stewing. So this happens, and then I will come to some conclusion, and then I'll talk to people. I'll talk to friends, and bounce it off some people, but usually not until I've kind of got some idea. I'm not really looking for a decision as much as I'm looking for what does this sound like to me if I tell it to you. I don't really want them to tell me what to do, I just want to hear what it sounds like.
>
> I think the storytelling part of it is very important, because somehow things have to make sense to me and I make sense out of them by telling people. When it sounds like it makes sense to me, then I think, well, that sounds like it makes sense. It's kind of group process. So it's processing it with other people, but coming to a decision myself.

Knowing I'm Right

In the course of our discussion, I asked each woman how she would know if a decision she had made was a good one, or the right one. It was an important question to have asked because the women's answers revealed another component of decision making. "Knowing I'm right" emerged as the third phase of the decision making process.

According to the women, how they came to know they had made a good decision depended on the nature of the decision itself and it took some time. As Rebecca described:

> There are times where I know right away, you know. Sometimes, well things like [when I started exercising]. That took time. It took going there for a month before I realized how good it felt, and I found muscles I didn't know I had. But that took time, and I think with most things, it does take time.
>
> You know, when I make decisions on an herbal product, I allow up to three months to try it and see how it works, because I feel three months is time enough. You need that space. It's not going to be instant. I don't think there are very many things where it doesn't take some time--other than buying a chocolate bar. Then I know [right away] that I made the right decision. I know as soon as I eat it, I know--oh yah, right decision. But for most things, I think we just have to wait awhile and see.

It became clear that "the knowing" if a choice for managing menopausal changes had been the right one, was related to the level of comfort a woman was able to achieve from the alternative she had chosen. Finding comfort or maintaining comfort, both physical and emotional, reinforced for her that the choice she had made was the right one. The relationship between satisfaction with her choice and the level of comfort which was provided by her choice was demonstrated most clearly by those women who had experienced a great deal of discomfort and disruption to their daily lives as a result of menopausal changes. The relief they experienced was more dramatic. However, women who had experienced less disruptive changes and whose primary choices had included alterations to their lifestyles including regular exercise and a healthier diet, demonstrated that being able to maintain their level of comfort also reinforced the appropriateness of their decision to manage their menopausal changes in this way.

Gina referred to the relief she had felt from the changes to her diet and the various herbs that were included in her regimen of care.

> It was incredible, just absolutely amazing and it was a sign to me that this was a physiological thing. I felt within a month like I was 18 years old again.

April's reaction to the change she felt once she began to take hormone therapy also reflected the relief from the physical discomfort she experienced:

> I started taking the pills and that was an awful big change, I tell you--a big change with the Estrogen. I could go through the hot summers and I could sleep at night without sweating real bad.

Susan as well spoke positively of feeling physical comfort as a result of taking hormone therapy. Making lifestyle changes and finding a new approach to dealing with

her family and co-workers provided her with emotional comfort. Both reinforced the appropriateness of Susan's choices for her.

> I just feel like I've got so much energy. I handle things in a different way. I don't know if it's just estrogen, but I think estrogen has given me that little extra.

> Now my life in the last 10 months or last year has changed so greatly, and it's just unbelievable. I've turned a lot of things around, and I don't know if it's the estrogen. I don't know if it's just a change, but I've made steps to start living my own life, and stop living everyone else's, and I think that's taken a lot of stress off.

These women also described an "emotional way of knowing" that a choice they had made was good for them. This element of " knowing" was similar to the emotional component these women had incorporated into the process of taking hold and making their choices about how they would manage their menopause. Their words indicated to me that this emotional way of knowing was an integral part of how they evaluated a decision. It was a rational and meaningful part of the process for these women. The following examples reflect the essence of this component of "knowing I'm right".

Emma's words suggest intuitiveness and spirituality are incorporated into the process for her:

> There's an instinct about it, in the first place. But in the second, there's a watchfulness where you assess it, and, you know, decide that it was a good decision, or if it wasn't, you change it.

> It depends on what the decision is about. Almost always when [I] make a large decision then [I] worry about it for awhile, but not always. Prayer plays a part, I think. I think that's what it is. Sometimes you can have a real sense of peace about something, even if it's a decision with difficult consequences.

Jane describes a process that reflects a connection between her mind and her body. Her words also suggest that she knows her body well and she listens to its messages.

> It has to come from somewhere like the core of my body before I really know, and I can tell. It's a physical feeling for me, and I do pay attention to those feelings I guess. I don't know when I started doing that, but it was a long time ago. I can just feel, you know, my stomach kind of tightens if I haven't worked through something or if there's somebody in my life that I have kind of a negative connection to, I feel that tenseness unless I work through or do something about it.

Laura put it very simply, "I guess on an emotional level, it feels right, then you stick with it."

Listening to My Body Again

Although the menopausal experiences of the eight women in the study varied, the nature of the choicemaking process was similar for all of them. Each experienced menopausal changes which they came to understand. Each of them made choices they felt were appropriate based on their beliefs and the circumstances of their lives. Each experienced satisfaction with the outcome of their choice whether it was due to relief from discomfort caused by menopausal changes or loss of weight from exercise. The "rightness of the choice" was reinforced for them.

What became apparent and defined the cyclical nature of the decision making process in general was that over time many of the women began to question their original choice. They began to "listen to their bodies once again" and once again the listening involved paying attention to both physical and emotional messages.

At the time of our discussion, both Emma and Gina had already made the decision to change from their original therapy. Emma had decided to discontinue hormone therapy while Gina had decided to discontinue the non-hormonal regimen she had been following and begin hormone therapy instead.

When asked what had been the greatest influence in her decision, Emma indicated that it had simply been her own thoughts about the inconvenience of taking a pill every morning of her life and she had begun to question whether she wanted to do that indefinitely. She described experiencing some discomfort from hot flushes initially, that it was "a bit rough at first, but not that bad." Emma did not look into any other ways of managing the hot flushes for two reasons: her physical discomfort from the hot flushes was manageable, and as she indicated, "I have taken herbs for other things and that has been very successful, but I just didn't want to take the time to go into a whole new method of--you know, discovery of something."

After following her dietary and non-hormonal regimen for approximately two years Gina also began to slowly question whether she wanted to continue to manage her menopause in this way. As she stated, "I guess there was a little piece of me that sometimes wondered what I was taking." She had begun to notice dark circles under her eyes and worried they were due to the therapy, but other factors also influenced her decision. The regimen of herbs that was prescribed required her to adhere to a strict schedule and took time to prepare. She described this as being fairly cumbersome as well as expensive.

> So I started taking hormones, and they worked almost just as well really. I mean they're easy, and they're much less expensive, so I'm still taking them. I don't think they're as effective, but maybe that's because I've backslid on the dietary part of it.
>
> I don't have quite the bounce--the energy, that I had a few years ago. I don't have the hot flashes and all of that anymore, so they [hormones] took care of that. They took care of the extreme mood swings. Sometimes I wonder if I went off them what would happen, and would I be okay.

April had continued with the original choice she had made but was beginning to consider doing something else. She described the process for her:

> I didn't question it then [taking hormone therapy] because my flushes were just too much....Then I kind of started to question it. The more I questioned it, the more information I got. The more I found out they really don't know that much about it [hormone therapy], and that's the part that started to worry me a little bit....There were times when I thought--well maybe without them, I'll see what I'm going to be like. Maybe it's time because some years have passed.

The experiences of those women who were either considering a change in the way they were managing their menopause or who had already decided to do so, reflect once again those themes that have been central to other phases of the decision making process. Emma described experiencing hot flashes when she discontinued hormone therapy, but was able to manage; April on the other hand was not able to discontinue hormone therapy because the hot flashes she experienced continued to be uncomfortable for her. Gina found hormone therapy not to be as effective in managing the changes she experienced with menopause, but was comfortable enough to continue.

Time and convenience of the chosen alternative were also factors that were considered, as well as other possible health issues that could occur for these women. For example, Emma stated, "if I was told I was at risk of a heart attack, or if I thought it would prevent osteoporosis, I would seriously consider it [taking hormone therapy] again." Susan indicated that if she developed a breast lump or cancer she would reconsider her choice.

Conclusion

These women indicated by their words and by their actions that having made a choice to manage their menopausal changes was not the end of the process. As

circumstances in their lives changed so often did their decisions. Instead their actions indicated that decision making in menopause was an evolving process, part of a life process. Just as their life experiences had influenced the choices and decisions they made about menopause, their experiences of menopause influenced other life experiences.

A very simple example illustrates this. Gina shared that her approach to health issues both for herself and her family had been greatly influenced by her experience in finding solutions for the discomforts she had encountered during menopause. Because she had not been able to find help through traditional medicine, she had been forced to explore alternative therapies and found a great deal of success. This influenced how she approached a subsequent health problem (unrelated to menopause) where traditional medicine offered a very invasive solution, which she questioned, while alternative medicine successfully offered another. As she stated, "I'm much more willing to give some of these things a try, you know, whether it's red cayenne or ginseng or whatever it is."

I would say that these women's beliefs about menopause was a factor which influenced their approach to how they chose to manage this transition, however, I do not believe it was central. I believe making choices for them was more about how they saw themselves as women; how they saw themselves moving forward. As Laura suggested, "what matters is being comfortable with yourself." Menopause was only a part of this larger process.

It is Gina who put it so well.

> There are a lot more choices in life than I might have thought there were, and there's more than one way to live, and there's more than one way to be, and there's more than one way for me to be.

CHAPTER V

Discussion

It is clear from this study that decision making in menopause is about much more than simply weighing the risks and benefits of an alternative and making a choice. It is a process that is intricately interwoven with all that has come before in a woman's life, all that she wants to come after, with her physical and emotional makeup, her relationships and her beliefs. In coming to the awareness that decision making in menopause could not be understood without also considering each woman's life circumstances, I chose to revisit human ecology theory as the basis for the framework to understand the process that each woman had embraced in order to come to the decisions she did.

Understanding Menopause from the Perspective of Human Ecology Theory

The discipline of human ecology provides a comprehensive framework from which to consider the human experience. Using an ecosystem approach, family becomes a system made up of individuals operating within the larger system of the society in which it is embedded (Westney, 1988). Such a framework suggests that the development of human beings is dependent on human interaction and the reciprocal relationships of the individual with persons in the family, neighborhood and community (Badir, 1993). From this perspective both human and environmental factors interact in determining the quality of life of people, posing limitations and constraints as well as possibilities and opportunities (Bubolz & Sontag, 1993; Westney, 1988).

I saw this demonstrated many times in the lives of the women in the study. For example, April had felt constrained throughout her life because of lack of money. As she

shared with me, "finances have been my biggest problem. It hasn't been menopause." Because of her financial and family situation, she felt that she had not had the time nor the resources to explore further options for managing her menopause. For April, her circumstances had posed limitations for her.

Rebecca's circumstances were somewhat similar to April's. She too was a single mother, she lived in a small apartment and was supported financially by a disability pension and social support. She lived with debilitating rheumatoid arthritis. Yet, in contrast, Rebecca embraced life. Her rheumatoid arthritis had not constrained her, instead she had become an expert in the use of herbal remedies and was successful in keeping this condition in remission; although she had had to give up working, Rebecca had begun a new career as a writer working from her home. For Rebecca, her circumstances had provided her with opportunities.

In human ecology theory the family is viewed as an environment in which individuals relate to one another in a variety of capacities and in which the problems of everyday life are worked out. The solutions to the problems, and the skills and resources that are needed to arrive at them, form the quality of life for each family and ultimately the individual. Elizabeth's circumstances certainly illustrate how it is possible for a family to find a solution to a problem and by doing so contribute to the well-being of all its members. Her story too demonstrates how one's circumstances can either pose limitations or opportunities.

Elizabeth's family had provided her with a strong support system. Because of her chronic depression, the whole family had become very aware of her emotional health, and she relied on them to let her know if they recognized a change in her before she did. This

family's experience with the chronic illness of a family member could have precipitated the breakup of the family. Instead their solutions to this very difficult situation had likely contributed to the quality of life for each member of the family and certainly for Elizabeth.

Viewed from the perspective of human ecology theory, the woman in mid-life has a much broader and more comprehensive perspective from which to examine her mid-life issues. The choices she will make surrounding menopause will not only reflect physiological and psychological processes but also her interaction with her home, her community and her culture. All provide a context for the meaning which she will give to menopause and the choices and decisions she makes. This was true about the women in this study.

The eight women who participated in this study had very different lives. Each had made sense of menopause in her own way and had made personal choices in her own way. Each of them had an expectation about menopause which was based on knowledge of their own bodies, what they had come to believe about themselves as women, and about becoming older women. Their understanding of their own menopausal experience had been influenced by knowledge of the nature of the experiences of other women including their mothers, their friends and colleagues. Their ability to understand their menopausal experience was also influenced by other resources each woman could draw upon from within her immediate community and the larger society.

If we embrace the principles of human ecology theory as having relevance for understanding a woman's menopausal experience, it follows that the nature of this transition for her will reflect her ability to utilize the skills and resources that are

available to her. Her life circumstances will present either limitations and constraints or possibilities and opportunities. It is for this reason that the findings of this study did not formally address the issue of barriers to a woman's ability to achieve her goals for managing her menopause.

There were circumstances in the lives of each of these women which had interfered with their ability to move forward in the decision making process. However, what was perceived to be a barrier for one woman was not perceived as a barrier in the same way for another. For example, April may have made different decisions if she had had the time or the financial resources to concentrate on her own needs. Rebecca, who had experienced similar circumstances, had achieved personal skills which had allowed her to make other choices. The quality of their lives was influenced by their ability to utilize the skills and resources that were available to them through their interactions with others in their families and in their communities.

Nature of Women's Decision Making Process in Menopause

According to Sandelowski (1981), health behavior is a process very much influenced by our physical, psychological and sociocultural environments. This author suggests that our ways of choosing are influenced by our concepts of self and the degree to which we can control the things that happen to us, as well as by our ability and willingness to solve problems concerning our own health.

This study would support this contention. It was important for the eight women in this study to feel that they were in control of what was happening to them and they believed the decision about a choice for menopausal management was ultimately up to them. Medical persons influenced these women's decision making, but did not make

choices for them. They were considered to be, and were utilized as a resource, someone who could help them to understand what was happening to them and could offer alternatives.

The process of making choices and decisions in menopause for these women was a thoughtful, rational process. They saw themselves as competent decision makers with specific decision making skills. They describe their skills in the following ways. "I've had some very good training in problem solving and decision making," "I can think about fairly complex things and sift out what isn't important," "I've got a basic education and I've had lots of practice making decisions," "I read. I absorb what I read. I investigate thoroughly. I ask questions. I think things through."

These women considered the risks and benefits of a therapy when making a choice, but as members of a family and a community, their choices also reflected their social roles and responsibilities. Each woman made her choices in her own way over a period of time. It was an evolving process in that the original decision often changed as the circumstances in her life changed.

Comparison of Findings with the Literature

The process these eight women embraced to make choices and decisions about menopause reflected many characteristics which were similar to those which have been described in the literature. For example, women choosing a childbirth method after a previous delivery by cesarean section also considered a variety of factors in their decision making which included medical information and advice (McClain, 1985; Murphy & Harvey, 1989). However, of equal importance to their decision making were expectations and goals which they perceived as being meaningful for them. These expectations and

goals reflected their desire to be in control of the decision, as well as their personal beliefs about the childbearing experience. Their expectations and goals also reflected the roles and responsibilities they assumed in other aspects of their lives. As in my study these women's reasons for supporting a plan of action were multiple and reinforcing in nature, not single dimensional and unconnected. In other words, making choices and decisions about this very personal issue was a complex process.

When we look to the literature which has specifically addressed women's decision making in menopause it has been noted that women clearly want to participate in the decision making process. It has also been demonstrated that women are competent decision makers in that they can process complex information, apply the information with consistency and understand the implications of the choices they make (Logothetis, 1991; Rothert et al., 1994; Salazar, & Carter, 1993; Ward, Heidrich, & Wolberg, 1989).

A review of the literature reflects other similarities to the women in my study. Logothetis (1991) found that women's decisions were not based to any great degree on how susceptible they felt to future menopausal problems or on their perceptions of the seriousness of other health issues as a result of menopause. This finding was evident in my study as well. The women in my study were aware of the significance of osteoporosis and heart disease in relation to menopausal women, as well as the debate associated with the use of hormone therapy and its possible link to breast cancer. The importance they gave to these factors throughout their decision making varied, but what seemed most significant to the women I talked with was how "personal" or "real" these health risks seemed to them at the time. As has been demonstrated in other studies, women in my study considered the same information differently (Rothert et al., 1990). Their personal

beliefs and the circumstances of their lives influenced the significance they attributed to individual factors in making a decision.

The Personal Nature of Women's Decision Making

After reviewing the literature about women's decision making in relation to health issues, I was left with an impression of the elements of the choicemaking process for women, but not of the process itself. This study offers some insight about the decision making process for women who are making important and complex decisions about a real life issue. Its most significant contribution, I believe, is the insight it provides about the personal nature of these women's decision making. That is, the emotional or even the spiritual component which seemed to define the decision making process for them.

The women in this study considered the advantages and disadvantages of an alternative before making a choice. They read, talked to others, and collaborated with their partners, but most significantly for them, these women knew their bodies and they listened to its physical, emotional and spiritual messages. They spoke of being intuitive, of knowing that a decision was right because it felt right. As Gina described, "...that's what ultimately sways the decision, a sense or a feeling of the right way to go." Elizabeth too spoke of putting off a decision because the feeling, the emotional aspect of the decision, was wrong.

Rebecca described this "intuitive process" as not being logical. "It just happens, you know." I would disagree with her and suggest that although not a formal strategy it was a central component of decision making for these women. Laura's words reflected this when she described how she often "processes" an issue, "I tend to get an idea and let it rumble around in my mind for awhile." Rebecca spoke of putting an issue aside and

choosing not to think about it for a period of time. As she said, "I find a lot of things come to me in my quiet times." Julia spoke of a similar process, but also incorporated "storytelling" as a tool she used to help her to make sense of an issue or a situation. "Things have to make sense to me and I make sense out of them by telling people."

As Murphy and Harvey (1989) noted, the women in their study considered childbirth to be a personal, feminine accomplishment and the choices and decisions these women made about a childbirth method reflected this. Menopause too is a personal, feminine experience. I believe that these women's stories support this. The decision making process they described suggests a personal, feminine way of making choices that is logical, rational, skillful and meaningful.

These eight women saw menopause as part of a life process, a part of their larger journey or experience. In coming to understand how they made choices and decisions about menopause it was necessary to understand some of that journey because it had shaped their personal beliefs and had defined who they were as women. They had lived as members of families and communities, they had careers, they had people who they depended upon and who depended upon them. Attention is beginning to be paid to women's personal beliefs and life circumstance as components of their decision making. However, to be truly meaningful menopause must be respected and valued by being incorporated as an essential element in the practices of health care practicioners and educators who work with women.

Implications for Further Research

The purpose of this study was to understand how women make deliberate choices to manage the issues associated with the transition of menopause during mid-life. It was

important to hear from women first hand about their experiences and to understand their perspective of the issues.

My objective in selecting participants for this study was to ensure that the women would be representative of a variety of menopausal experiences. I believe that I was successful in doing this and was able to capture similarities across the span of their different experiences which provided insight into the process which defined their decision making. However, I have come to realize that for the most part the women in the study had reached a place in their decision making where they were generally comfortable with their decisions. They spoke of their experiences retrospectively, which provided them with some distance from the concerns and issues which had prompted their initial decision making. What they had felt and experienced, they had been able to place in perspective within the context of other events and circumstances which had occurred. This could also be a strength of the study, however, I feel it would be meaningful to compare these women's views of the process with women who were enmeshed in the experience at the time of the study. It must be kept in mind that perspectives change with time and that understanding of self and experience may also change. Therefore, conducting the study in a future time or with other groups of women such as those who live in poverty, or women who have no source of support, for example, may produce different results.

The women who participated in the study varied in age and education, but generally they were a well-educated and financially secure group of women. Although the age of the women ranged from 42 to 66 years, all the women except one were 50 years and older. It may be that women who are older and who have essentially passed through

menopause are at a different place in their lives than younger women. They may face different issues which would influence their approach to decision making. The core category of achieving wholeness in these women's lives which evolved from the study, may be a reflection of the age of the women who participated.

A central premise of this study has been that the process of decision making in menopause is an evolving process, one that changes as women's life circumstances change. The process which has been described reflects this assumption. Although this study was able to provide a somewhat longitudinal perspective of the process by interviewing women over a span of time, to more fully understand the evolving nature of women's decision making it may be helpful to offer a broader longitudinal perspective than was possible in this study.

A strength of this study I feel has been its ability to describe the components of the process of decision making in menopause. However, by doing so, it was not possible to focus in particular detail on any one issue, for example, the influence of a woman's beliefs about her sexuality on her decision making, or how a woman's way of choosing is affected by the degree to which she is able to control events and circumstances around her. Once again future study with other groups of women will be helpful in contributing to our understanding of how specific issues and circumstances affecting women's lives may influence their decision making.

Implications for Practice

Because each woman's experience of menopause is her own, women demonstrate a range of knowledge and understanding about the transition, experience a variety of changes as well as individual responses to these changes. Not surprisingly there are a

variety of choices and decisions women will make to manage this transition in a way that is meaningful for them.

Since there is no one answer regarding menopausal management, a variety of resources must be available to women. They need access to unbiased, accurate and reliable information to assist them in their decision making. Programs are required that provide consistent consultation and information for women with an emphasis on education, prevention and wellness.

There is a need to respect the personal nature of women's decision making that takes into account the roles and responsibilities that women assume in all aspects of their lives. Educational programs must be sensitive to the changing world that women find themselves which often contributes to anxiety and stress because of its complexity. Educational programs must allow women to make choices in menopause in their very personal way and of equal importance, educate women that their personal way of choosing is a legitimate component of decision making.

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APPENDIX A

Informed Consent Form

Project Title: Choices and Changes: Women's Experience of Decision Making in Menopause

Researcher:
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Professor
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The following aspects of this research project have been satisfactorily explained to me:

1. The purpose of this research project is to understand, from the perspective of women, the process of making deliberate choices to manage the issues associated with the transition of menopause during mid-life.
2. A maximum of three interviews will be conducted with me.
3. The interviews may take place in my home, at the University of Alberta, or another mutually convenient place.
4. Each interview will last one to two hours.
5. Each interview will be tape-recorded and transcribed by the researcher.
6. A summary of the research report will be made available to me at my request.

I understand there may be no direct benefits to me for participating in this study, but that it is hoped the study will provide an understanding of women's perceptions and experiences about making choices and decisions during menopause. As a result, the kind of information women need in order to be able to manage the menopausal transition in a manner that is relevant and meaningful to them may become more clear.

I hereby give permission to be interviewed and for the interviews to be tape recorded and transcribed. I understand that the tapes and transcriptions will be identified only by code numbers. My name and address will be kept in a separate locked file, and this file will be destroyed after the completion of this study. I understand that any identifying information on the transcriptions will be deleted and that the tape recordings will be destroyed after the completion of the study. I understand that the researcher will only discuss information from the transcripts with her thesis supervisor and the major researchers in the original study, *Choices & Changes: Mid-Life Women's Choicemaking About Menopausal Management*. I understand that at no time will my name be included in any written communication or discussions with these individuals.

Information and findings from this study may be published or presented at conferences, however, any material that may identify me will not be used. I give consent

for subsequent analysis of the transcribed interviews. I understand that the transcribed interviews may not be used for any other purpose without my prior content.

I understand that I am free to refuse to participate in this study, to refuse to answer any questions, and to withdraw from the study at any time by contacting the researcher. I have had the opportunity to ask questions and these questions have been answered to my satisfaction.

This is to certify that I _____, hereby agree to participate as a volunteer in the above named project.

_____	_____
Signature of Participant	Date
_____	_____
Signature of Researcher	Date

Please send me a summary of the study when it is completed:

Name: _____

Mailing Address: _____
_____
_____

APPENDIX B

Examples of Guiding Questions for Interviews

It should be noted that these questions are meant to be examples of general themes that will guide the interview. Questions will not necessarily be asked if they are not applicable to a particular participant.

1. Tell me what menopause means to you?
2. Where are you in your own menopause transition?
3. Every woman has a particular pattern of responding to situations in which there are choices. How do you usually handle these situations?
4. What situations with respect to mid-life changes have required choices for you?
5. Describe how you handled one of them.
6. How have health or family issues influenced your choices?
7. What issues with respect to menopause have arisen for you?
8. What if any choices have you made so far to manage your menopause?
9. How do you determine that you have made a good choice for you?